

***United States Court of Appeals
for the
District of Columbia Circuit***



**TRANSCRIPT OF
RECORD**

JOINT APPENDIX

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 18,823

GEORGIANA HARVEY

Plaintiff-Appellant,

v.

UNITED STATES OF AMERICA

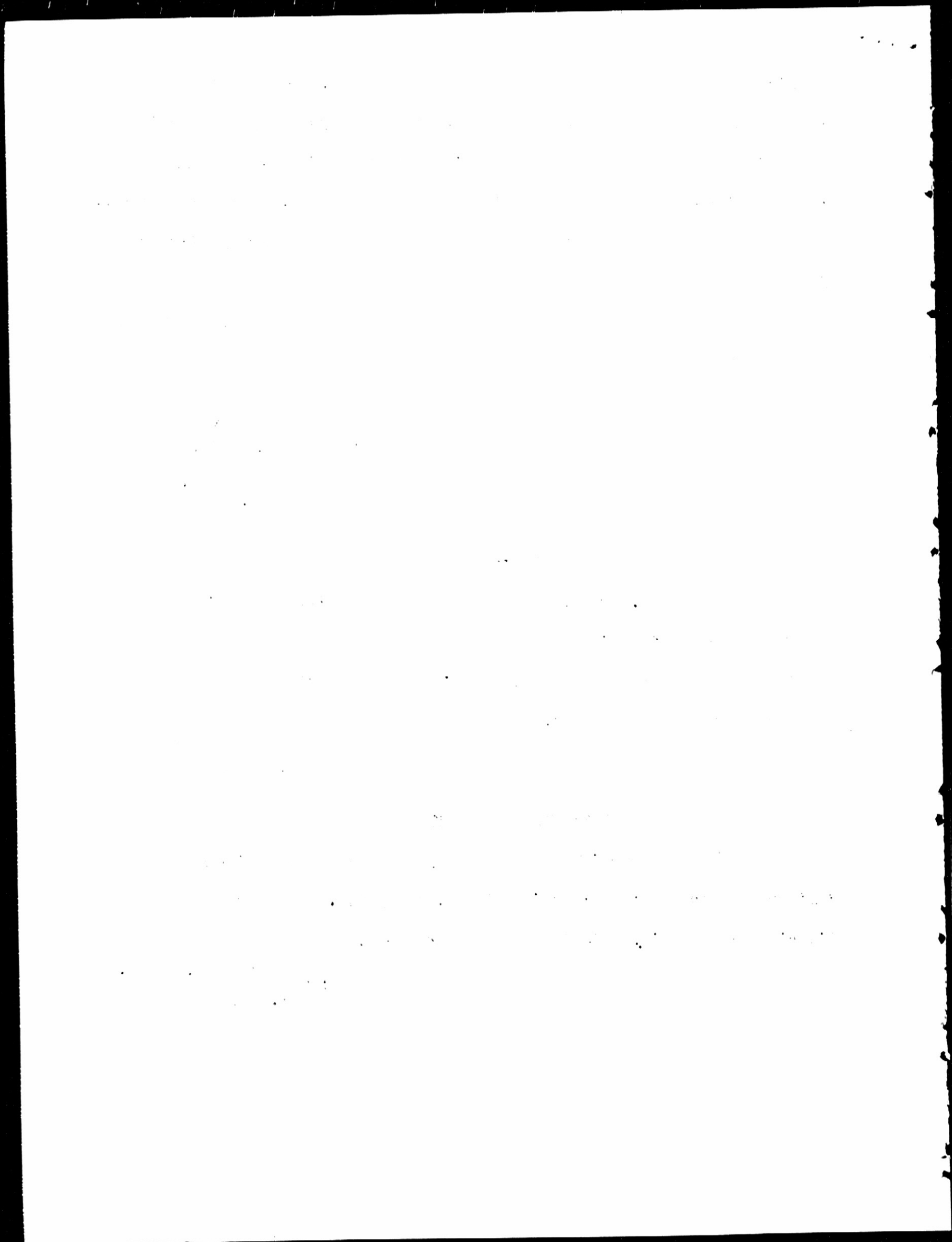
Defendant-Appellee.

Appeal from the United States District Court
for the District of Columbia

United States Court of Appeals
for the District of Columbia Circuit

NOV 12 1964

Nathan J. Paulson
CLERK



(i)

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

GEORGIANA HARVEY
and
JULIAN HARVEY
2001 N. W. 14th Street
Miami, Florida

Plaintiffs

v.

UNITED STATES OF AMERICA
Defendant

Civil Action No. 533-59

COMPLAINT UNDER FEDERAL TORT CLAIMS ACT
Filed February 24, 1959

1. This action is brought under the Federal Tort Claims Act, 28 U.S.C. 2671 et seq; 28 U.S.C. 1346(b), as hereinafter more fully appears. Plaintiffs, Georgiana Harvey and Julian Harvey, are husband and wife, citizens of the United States and residents of the State of Florida.

2. On or about February 15, 1955, plaintiff wife was a duly admitted patient at Bolling Air Force Base Hospital in the District of Columbia. Said hospital was owned and operated by defendant and was staffed by defendant's agents, servants and employees. Then and there defendant's agents, servants and employees negligently and carelessly performed a surgical operation on the female organs of plaintiff wife. Knowledge or information as to such negligence was withheld from plaintiffs and was not discovered by them until February 12, 1958 when, as a result of the aforesaid negligence, it became necessary to perform a complete hysterectomy on plaintiff wife.

3. As a result, plaintiff wife has suffered great pain of body and mind, and will in the future continue to suffer great pain of body and mind; has suffered a complete removal of her female organs, and has been rendered unable to bear children. Plaintiff husband has incurred large expenditures for medical care and treatment of plaintiff wife, has been

deprived of her consortium, and has been otherwise injured.

WHEREFORE, plaintiff Georgiana Harvey demands judgment of the defendant, United States of America, in the sum of Two Hundred Fifty Thousand Dollars (\$250,000); and plaintiff, Julian Harvey, demands judgment of defendant, United States of America, in the sum of Fifty Thousand Dollars (\$50,000) and costs of this action.

ANSWER

Filed April 24, 1959

First Defense

The complaint fails to state a claim upon which relief may be granted.

Second Defense

The complaint is barred by the Statute of Limitations.

Third Defense

Answering specifically the allegations contained in the numbered paragraphs of the complaint defendant avers:

1. Defendant is not required to answer to the allegations of jurisdiction contained in paragraph 1 of the complaint. Defendant is without knowledge or information sufficient to form a belief as to the truth of the remaining allegations contained in paragraph 1 of the complaint.

2. Defendant admits that on or about February 15, 1955, it owned and operated the 1100th U.S.A.F. Hospital, Bolling Air Force Base, District of Columbia; that on said date the aforesaid hospital was staffed by defendant's agents, servants and employees; that on said date, while plaintiff, Georgiana Harvey, was a duly admitted patient in said hospital an operation was performed upon plaintiff, Georgiana Harvey, by defendant's agents, servants and employees, to remove a right tubal (ectopic) pregnancy.

Defendant denies that any or all of the injuries allegedly suffered by plaintiff, Georgiana Harvey, resulted from any negligence or carelessness on its part or on the part of its agents, servants or employees. Defendant further denies each and every other allegation contained in this paragraph 2 of the complaint, not herein specifically denied.

3. Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph 3 of the complaint.

WHEREFORE, having fully answered, defendant demands judgment, together with the costs of this suit.

[Filed December 12, 1961]

**ORDER DENYING DEFENDANT'S MOTION FOR
JUDGMENT ON THE PLEADINGS AND DEFENDANT'S
MOTION FOR SUMMARY JUDGMENT**

Upon consideration of defendant's motion for judgment on the pleadings or in the alternative motion for summary judgment, memorandum of points and authorities filed in support thereof, the statement of defendant pursuant to Local Civil Rule 9, the points and authorities filed by plaintiff in opposition to defendant's motions, the supplementary points and authorities in opposition to said motions, the oral arguments of counsel in open court, and all of the pleadings, interrogatories and answers, and depositions on file referred to in the foregoing materials, it is by the court this 12 day of December, 1961

ORDERED that defendant's motion for judgment on the pleadings, or motion to dismiss, be and the same hereby is denied, and it is

FURTHER ORDERED that defendant's motion for summary judgment be and the same hereby is denied.

/s/ Joseph C. McGarraghy
Judge

Sept. 12, 1962

PRETRIAL ORDER

Action for malpractice under the Federal Tort Claims Act.

THE PARTIES AGREE & STIPULATE TO THE FOLLOWING STATEMENT OF FACTS:

The D, in Feb. 15 1955, operated and owned a hospital at Bolling Air Force Base, Washington, D. C. On said day, the female P, then 28 years of age, was admitted to the hospital. The male P, since the institution of this suit, and prior to the order placing this cause on the Ready Calendar, died, as indicated by the suggestion of death filed June 9, 1962.

The action therefore, brought by Julian Harvey, is dismissed with the consent of counsel who instituted this action in his behalf.

The D admits the agency of the doctors and other personnel of said hospital, and that on said date, the P underwent a surgical operation in said hospital.

PLAINTIFF CLAIMS that she was operated upon for a suspected ectopic pregnancy and that she was effectively sterilized by the surgical mutilation of her right fallopian tube, the left tube having been removed some years previously, said mutilation consisted of a partial right salpingectomy. P claims that the malpractice and her injuries and damages resulting therefrom derived from the negligence of the agents or employees of the D in that the mutilation described above was unnecessary to accomplish the purpose for which the operation was performed; that what was done by the physicians was accomplished without adequate consultation with the P and without adequate consultation with other physicians; that the operation was performed by a physician of limited experience and qualifications in that the physician had performed only one or two operations of this type; he was not certified as a gynecological surgeon and he was not certified as a surgeon; and his prior experience in gynecological surgery had not been under adequate supervision; that he proceeded upon insufficient information in that he relied solely upon P's

history and his examination and a precipitous diagnosis made by him.

P relies on the doctrine of *res ipsa loquitur* for proof as to the negligent manner in which the operation was performed.

P asserts that all of the foregoing acts and omissions of the D's physician were contrary to existing standards of care and treatment then and there required.

P further contends that there was no pregnancy, or in the alternative, if there was pregnancy, no emergency situation existed because any such pregnancy was in an incipient stage and the physician should not have proceeded.

P asserts further that knowledge or information as to all of the foregoing negligence now claimed by her or of facts which would furnish such knowledge or information were withheld from her, leading her to believe that the removal of her remaining Fallopian tube was an emergency measure to save her life, such as had been the case when her left Fallopian tube was removed in consequence of a ruptured tubal pregnancy in 1953.

DEFENDANT denies that it was negligent in any respect, denies the withholding of any knowledge or information, and denies that the alleged negligence necessitated a hysterectomy. The surgical procedure was performed in accord with the customary and usual standards of care and treatment rendered under like conditions and circumstances in the District of Columbia in February of 1955.

D contends that the action is barred by the statute of limitations and that any action for the withholding of information is specifically barred, as an action for fraud or deceit, by the Federal Tort Claims Act, 28 U.S.C. 2680(h). D further contends that female P was not damaged as alleged and that subsequent medical treatment, if necessary, was not caused by the incident procedure or by any negligence in connection therewith.

Statute of Limitations:

The applicable limitation is two years as provided by 28 U.S.C. 2401(b).

Time expired on February 15, 1957. Suit was not filed until February 24, 1959, four years after the operation.

The cause of action accrued on Feb. 15, 1955 because P had knowledge of the removal of her tube and its consequences on that date. Deposition of Georgiana Harvey, January 6, 1960, pp. 25-26, 36, 46, 48-49, 54-55 and Deposition of James L. Eavey, December 15, 1960, pp. 54, 59-60.

PLAINTIFF'S INJURIES

As a result of the negligence of the D's physician, the P had to submit to an operation for peritonitis on Feb. 25, 1955 by the D in the same hospital, with the scarring attendant upon an abdominal operation and mutilation and scarring of the female organs; continued pain and bleeding: treatment for what appeared to be a miscarriage in September of 1956 and again in the spring and summer of 1957, being necessary because of D's negligence and a radical hysterectomy at Sacred Heart Hospital in Pensacola Feb. 12, 1958.

Pain and suffering; mental anguish.

P claims a permanent injury in the loss of her remaining female reproductive organs with the resultant inability to bear children.

P also claims permanent associated emotional disturbance.

NOTE: At pretrial, counsel for P had no written medical evidence to sustain the claim of permanent associated emotional disturbance.

SPECIAL DAMAGES

Dr. J. C. Wilson, Ft. Walton Beach, Fla.	\$ 8.00
Dr. Grant Holmes, 1602 East LaRua St., Pensacola, Florida	135.00
Dr. Frederick R. Braden, 1900 N. Palafox St., Pensacola, Fla.	270.00
Sacred Heart Hospital, Pensacola (approx)	200.00
Drs. Jose Gurri, Dr. Arristides Mendendez, Dr. Santa Marina, all of Havana, Cuba	30.00
Dr. James Vaughan, 5965 Ponce de Leon Blvd., Coral Gables, Fla.	30.00

STIPULATIONS

The following may be admitted in evidence without formal proof, subject to all proper legal objections: hospital records;

The parties agree to the mutual exchange of all medical reports of examining or treating physicians, now in hand, on or before Oct. 2, 1962, and a similar exchange of all other such reports within 48 hours of the alert of this case for trial.

Counsel for P agrees to make the P available for the purpose of a physical examination by physician of D's choice before, but not to interfere with, trial.

Counsel for the P will furnish to counsel for D, on or before September 17, 1962, with a written statement, which will be supplied by the D, which will enable the D or its representatives to obtain the medical records of Drs. James A. Vaughan, Jr. and Dr. Frederick R. Braden, Sacred Heart Hospital, Pensacola, Fla., and Dr. J. C. Wilson with reference to the female P, provided, however, that upon receipt thereof of said records by D, same may be admitted in evidence without formal proof, subject to all legal objections.

Counsel for P will furnish to counsel for D, and the Clerk of Court, on or before Sept. 25, 1962, a list containing the names and addresses of all witnesses whom counsel intends to produce at the trial.

The Defendant may call the following witnesses:

James L. Eavey, M.D., 125 Valencia Road, Rockledge, Fla.,
Stafford W. Hawken, M.D., 1150 Conn. Ave., n.w., Wash., D.C., any other
witnesses whom the D will call are to be furnished to counsel for the P,
and the Clerk of Court, in writing, on or before Sept. 25, 1962.

The deposition of James L. Eavey, M.D. taken Dec. 15, 1960 may
be admitted in evidence.

The deposition of Georgiana Harvey, the female P, may be admitted
in evidence.

TRIAL COUNSEL: Landon G. Dowdey, Esq. for the Plaintiff;
Sylvia A. Bacon, Esq. for the Defendant.

The Examiner has requested counsel for D to appear at trial with
the maximum amount of authority to settle this case which will be allowed
him by his principal.

OBJECTION TO PRETRIAL ORDER

Comes now the defendant by and through its attorney, the United
States Attorney for the District of Columbia, objects to the pretrial order
entered herein on September 12, 1962 and requests that certain portions
thereof be struck or in the alternative that the cause be removed from the
ready calendar for the following reasons:

1. The pretrial order amends the complaint.
 2. The pretrial order fails to remove the cause from the ready
calendar or to allow discovery with respect to the new allega-
tions.
-

[Filed Oct. 2, 1962]

ORDER

Upon consideration of defendant's Objection to Pretrial Order and the oral argument of counsel thereon, it is by the Court this 2 day of October, 1962,

ORDERED that defendant's request to strike certain portions of the Pretrial Order be and the same hereby is denied and it is

FURTHER ORDERED that the above captioned cause be and the same hereby is removed from the ready calendar for a period of 60 days for the purpose of further discovery by the parties.

/s/ Matthew F. McGuire
United States District Judge

DEPOSITION OF JAMES L. EAVEY, M. D.

Deposition of James L. Eavey, M. D. a witness of lawful age, taken on behalf of the Plaintiff, * * * before * * * a Notary Public * * * at * * * Cocoa, Florida, on the 15th day of December, 1960.

* * * * *

2

DIRECT EXAMINATION

BY MR. DOWDEY:

Q. Will you state your full name, please, sir? A. James Lee Eavey.

Q. And where do you live, sir? A. 125 Valencia Road, Rockledge, Florida.

Q. And what is your profession? A. Physician. Specifically, gynecologist, obstetrician.

Q. And where is your office? A. Presently in Brevard Hotel, Cocoa, Florida.

* * * * *

3

A. Since late March, 1959.

Q. And prior to that time you maintained an office in Baltimore?

A. That's correct.

Q. At 3901 North Charles Street? A. That's correct.

Q. For how long did you maintain your office there? A. From August, 1955, until March 1959.

Q. And prior to that where did you maintain your office? A. Prior
4 to that I was in the United States Air Force located at Bolling Air Force Base, Washington, D. C.

Q. And during what period of time were you stationed there at Bolling? A. 1948 to 1952, and then again in 1953-1955.

Q. And were you separated from the service in 1955? A. That is correct.

Q. Do you recall the month of August, I'm reasonably sure, while you were not in Bolling, where were you, Doctor? A. In my last year of formal residency and training at the University Hospital at Baltimore, Maryland.

Q. And when was that? A. 1952 to 1953. July to June, if you want to add that.

Q. Were you in the service at that time? A. Yes.

Q. And prior to 1948 where were you, Doctor? A. In---I don't know whether it would be better to state this in chronological order or not. It might make it easier for you.

Q. You can. I have been going backwards. That's usual. A. All right. The preceding year, residency training, University Hospital, Baltimore, Maryland.

5 Q. And by the preceding year you mean 1947? A. July 1947 to June 1948, approximately.

Q. And were you in the service then? A. Not on active duty.

Q. And prior to your residency, 1947-1948, what were you doing?
A. April 1946 to June 1947, rotating internship, University Hospital, Baltimore, Maryland.

Q. Would it be fair to say, Doctor, that until 1955, your medical experience was either the Bolling Air Force Base Hospital or University Hospital, Baltimore? A. That is correct.

Q. And you maintained no private practice or other practice during that period? A. During that period, no.

Q. When were you born, Doctor? A. October 31, 1922.

Q. And where? A. Sharpsburg, Maryland.

Q. Where did you receive your formal education? A. Medical school?

Q. Well, your collegiate training? A. Undergraduate school Franklin and Marshall College, Lancaster, Pennsylvania.

6 Q. When did you graduate? A. 1943. Medical school, University of Maryland, Baltimore, Maryland, graduated 1946.

Q. When did you enter the service, doctor? A. Active duty?

Q. Well, or otherwise. A. Well, I first entered the Reserve, Medical Administrative Corps in 1942, and ASTP during medical school, reserve commission, Medical Corps in the United States Army upon graduation of medical school. Active duty, US Air Force, Medical Corps, until June or July, 1950. Excuse me, 1948.

Q. After you were graduated from medical school, did you take any further training, and if so, what training? A. The rotating internship as described for 15 months.

Q. And where was that? A. The University Hospital in Baltimore. Then, a year of residency training in gynecology and female urology, University Hospital in Baltimore.

The next four years at Bolling was credited by the American Board of Gynecologists and Obstetricians, as representing partial formal training towards certification. The year '50 [July]---'52, till June 1953, residency training in gynecology and female urology, University Hospital, Baltimore, Maryland.

7 Q. When were you certified? A. By the American Board of Obstetrics and Gynecology in 1957.

Q. Were you certified to any other specialty? A. No, sir.

Q. Are you now a practicing gynecologist? A. Yes, and obstetrician.

Q. You maintained that specialty throughout? A. That is correct.

Q. Have you published any papers or texts? A. No, sir.

Q. Have you delivered any lectures to learned societies or taught?
A. Yes.

Q. When and where? A. During the years 1955 to 1959, on several occasions addressing the gynecological-obstetrical staff at the University Hospital, and similarly the hospital staff in Eastern Salisbury, Maryland. Specific dates I cannot think of.

Q. Is there any report of those lectures? A. No records were kept of such, no. At least to my knowledge.

* * * * *

8 Q. Doctor, as of February, 1955, what experience had you had in the diagnosis of tubal pregnancy throughout the time from internship in 19--

9 following 1946 until that --- until the stated time? A. I had numerous occasions to make the diagnosis of tubal pregnancy, and from 1947 on had performed numerous operations for same procedure. Exact numbers I cannot recall.

Q. I was referring to diagnosis at this point, doctor. A. All right.

Q. In 1946, you say you had occasion to diagnose a number of tubal pregnancies as an intern? A. I would like to interrupt. I did not make that statement.

Q. Yes. Well, I'm not trying to trip you. A. Okay.

Q. I perhaps misunderstood you. If you will just tell us what it was. A. Well, simply that from that year through until, and until 1955, that I had during internship probably not more than two or three times did I have occasion to make such diagnosis.

Q. All right. And that was on your own or with assistance while you were an intern? A. My diagnosis as an intern was obviously not the

diagnosis that was utilized in definitive therapy, but in conjunction with the aid of residents or visiting staff.

10 Q. I see. And were those--you say there were two or three perhaps? A. Perhaps.

Q. As an intern during the fifteen months of your internship. Do you recall whether those were ruptured or unruptured tubal pregnancies? A. The overwhelming majority of tubal pregnancies when diagnosed have ruptured.

Q. We are just referring to the ones that you have diagnosed, Doctor. Do you recall an instance of having diagnosed an unruptured pregnancy during internship? A. During internship I do not recall any such diagnosis.

Q. Now, thereafter, as a resident I believe it was--if I'm incorrect, please correct me--you were a resident for a period at University Hospital, 1947-- A. To 1948, a year of residency.

Q. All right. A. Yes, sir.

Q. All right, and during that time did you have occasion to diagnose tubal pregnancies? A. Yes.

Q. And how many, would you say? A. I honestly can't recall even an approximate number.

11 Q. Well, did you have occasion to diagnose any unruptured tubal pregnancies during that period 1947-1948 as a resident at University Hospital? A. To my best recollection the probability is that I did not.

Q. Now, I'm proceeding then, if I recall correctly, from 1948 to 1952, you were at Bolling Air Force Base Hospital in Washington, D. C. Did you have occasion during that period to diagnose tubal pregnancies? A. Yes.

Q. And approximately how many? A. Again, I can't recall even approximate figures.

Q. Do you recall having seen or having diagnosed an unruptured tubal pregnancy? A. Yes.

14

Q. How many? A. Not more than two or three.

Q. That's during the period of 1948 to 1952 at Bolling Air Force Base Hospital? A. That's correct.

Q. Did you make such diagnoses on your own or with assistance?
A. These diagnoses that I refer to were on my own.

Q. Did you consult with anyone on these diagnoses, 1948-1952, of the several unruptured tubal pregnancies you described? A. There were
12 always other members of the obstetrical-gynecological staff and invariably when diagnosis was finally established at least one of these men was involved.

Q. Was there a formal consultation? A. Not as such.

Q. Did surgery follow? A. Yes.

Q. From--did you perform the surgery? A. The surgery while in the Air Force was divided among the members of the staff, and the number of these procedures, yes, I did myself.

Q. Well, referring to the period 1948 to 1952, and during that time, I understood you to say that you had occasion to diagnose how many such unruptured tubal pregnancies? A. Not more than two; two, three.

Q. Two or three. During that same period did you have occasion to operate on any of these unruptured tubal pregnancies? A. Yes.

Q. How many? A. Again, I'm uncertain, but I think that of the unruptured ones it is my recollection that I did all of the operations on those.

Q. And that would be two or three during that period? A. Two or
13 three.

Q. How were those--what type of operations were they? A. Well, one or so were via posterior colpotomy, and at least one that I recall was done via laparotomy.

Q. During the period 1953 -- pardon me, 1952 through 1953, while you were in residence at University Hospital at Baltimore, did you have occasion to diagnose any unruptured tubal pregnancies? A. I'm uncertain, and I would like to point out that because of the nature of residency practice, residents do not see people with this problem usually until they have

undergone either rupture or tubal abortion.

Q. So the answer would be that you are doubtful whether you had occasion to diagnose any -- A. Just doubtful.

Q. --unruptured tubal pregnancies during the period of your residency at University Hospital in Baltimore?

MR. HANNON: Excuse me. Does that include both years of residency?

MR. DOWDEY: He discussed them earlier. I understood it was 1952 through 1953.

A. This was the formal year, and then the previous formal year, 1947-1948, we have already covered.

14 MR. HANNON: And your answer was that was for both years of residency?

WITNESS: Yes, as far as the nature of the type case one sees in residency training.

BY MR. DOWDEY:

Q. Very well. Now, coming to period 1953 through 1955, you were again at Bolling Air Force Base Hospital. Did you, during that time, have occasion to diagnose any unruptured tubal pregnancies? A. Are you referring to this complete time now, or up to the--

Q. Up to February 15, 1955. A. Hmm mmm. Perhaps once or twice. Again, this is very uncertain as to number.

Q. And did you in those perhaps one or two instances you made the diagnosis, also perform the surgery? A. As I recall, yes.

Q. I take it, Doctor, that throughout this period we are referring to now, the period of your internship, residency and service at the Bolling Air Force Base Hospital, you had occasion to diagnose many ruptured tubal pregnancies, am I correct in this? A. That is correct.

Q. Would you hazard a guess on the number? A. This is a hazardous guessing, but roughly, I would say perhaps in the neighborhood of 50, plus or minus.

Q. And during that same period, did you perform surgery with
15 respect to a ruptured tubal pregnancy? A. Did I at any time do
so?

Q. I'm sorry, I'm sure you did. I was asking you if you might
hazard a guess on how many times you performed surgery with respect
to a ruptured tubal pregnancy? A. Because of the pattern of handling
such cases, it is my guess that the overwhelming majority of the cases
I diagnosed I likewise performed surgery. Particularly, inasmuch as
most of them are emergency procedures.

Q. In the case of the ruptured tubal pregnancy you refer to, that
you performed surgery with respect to, did you ever proceed other than
by laparotomy? A. The question is, "ruptured"?

Q. Yes. A. Well, perhaps I should make it clear that, that the
word "rupture" infers that there has been a literal breaking through of
the tubal wall. Now, a great many tubal pregnancies are classified as
ruptured when really they represent tubal abortions with bleeding occur-
ring out the end of the tube into the abdominal cavity, without the rupture
of the tube--of the tube in strict sense. Now--

Q. Well, I assume, Doctor, that in all of the previous testimony
when you have used ruptured tubal pregnancy, you are referring to strict
rupture, and not abortion. A. As a matter of fact, no. In classifying a
16 tubal pregnancy as ruptured this normally infers that the pregnancy
is essentially intact, and if there were, let's say, a very small amount of
ooze of blood out of the end of a tube, this perhaps might be classified
as unruptured and yet really it is an early or beginning tubal abortion.

Q. Perhaps you misunderstood me. I said that in your previous
testimony where you have referred to the ruptured, not unruptured but
ruptured tubal pregnancy, you refer to strict rupture. A. No, I did not.
I referred to both strict rupture and, and the tubal abortion in which
there is considerable hemorrhage into the abdominal cavity. Are we
straight now?

Q. Well, yes. A. I want you to be.

Q. It modifies your previous testimony somewhat. A. Yes, and also makes it give good reason as to why the diagnosis of a tubal pregnancy is a relatively uncommon thing. Now, if you--an unruptured tubal pregnancy would not be uncommon if one was to include tubal abortions among them. The reason for the rupture, probably is, whether it be rupture or whether it be tubal abortion, the amount of bleeding is really, in the final analysis, the important consideration.

Q. Well, let's backtrack a little bit, then. A. All right.

17 Q. When I asked you questions year by year, first covering your internship-- A. Yes, sir.

Q. 1947, or 1946 to 1947, your residency in 1947, you were unable to estimate the number of tubal pregnancies you had occasion to diagnose. However, you did have occasion, I believe your testimony is you may have seen one or two unruptured tubal pregnancies. Now, did you mean strictly unruptured tubal pregnancies, did you mean abortions, or did you mean perhaps pregnancies that were ruptured? A. In all the testimony referring to unruptured tubal pregnancies, I referred to those in which the tubal pregnancy was still intact, or at most with the very earliest of beginnings of tubal abortions.

Q. I see. So that all of your testimony where you used the word "unruptured" refer to strictly unruptured or border-line unruptured tubal pregnancies? A. Right. Correct.

Q. Whereas, when you referred to ruptured tubal pregnancies in your previous testimony, you include therein a number of abortions? A. Right.

Q. Tubal abortions. I just wanted to have your testimony clear on that point. A. Hmm mmm.

18 Q. Now, with respect to ruptured tubal pregnancies or tubal abortions that you diagnosed or that you operated upon, did you ever have occasion to proceed other than by laparotomy? A. For diagnosis, yes. For therapeutic surgery, no.

MR. HANNON: Excuse me a minute. Would you read the question to me, please, and the doctor's answer?

(The question beginning at line 2 above, and the answer at line 6, above, were read.)

MR. DOWDEY: Okay.

MR. HANNON: Hmm mmm. Thank you.

BY MR. DOWDEY:

Q. Would you describe briefly the "yes" part of your answer to that question? A. On establishing the diagnosis of a tubal pregnancy, ruptured or unruptured, there are several means available. In the instance where there has been severe intra-abdominal blood loss, the diagnosis is often fairly clear and perhaps most often laparotomy is carried out without further diagnostic procedure necessary. In many instances it becomes advantageous to utilize procedures such as examination under anesthesia, aspiration of the cul-de-sac of Douglas in order to determine the presence or absence of blood in the abdominal cavity, by utilization
19 of a colpotomy which represents an incision in the upper end of the vaginal vault, into the cul-de-sac of Douglas, and thereby establishing presence or absence of blood, and in many instances being able to visualize the structures of the pelvis including the tubes and ovaries.

Still another procedure that is sometimes utilized is culdoscopy, in which an instrument is literally punched through the upper end of the vagina and the structure is visualized by way of a lighted prism system.

Q. Have you finished your answer? A. Yes. One could likewise consider that exploratory laparotomy might be in itself a diagnostic procedure. That's it.

Q. What you have just described are the techniques of diagnosis?
A. Correct.

Q. And I think your language is quite clear enough, except in popular usage we sometimes abuse the word "visualize". You mean actually see?

A. Actually see.

Q. These organs that you have described? A. That's correct.

Q. Would you like some water to drink?

(Discussion off the record.)

20 Q. I think we have treated sufficiently with the ruptured tubal pregnancies and tubal abortion. Coming now to your experience as of February, 1955, with respect to the diagnosis and the treatment of unruptured tubal pregnancies, I think the total your estimates comes to from four or five, am I correct? A. That would seem about right.

Q. Now, of those four or five treatment procedures were used?
A. To the best of my recollection, prior to February, 1955, I had actually removed three or four essentially unruptured tubal pregnancies by way of the colpotomy incision. I perhaps should add that many other times through such an instance, whether I was looking for tubal pregnancies or not, I had occasion to do other surgery such as removal of small ovarian cysts.

Q. So you say three or four were by colpotomy? A. Right.

MR. HANNON: May I ask a question off the record?

(Discussion off the record.)

MR. HANNON: I was asking the doctor, for my information, when I interrupted Mr. Dowdey, whether there was any difference between colpotomy method and posterior colpotomy?

21 WITNESS: Actually, posterior colpotomy is more specific and means that the incision is made posterior to or behind the cervix. There is such a thing as anterior colpotomy, the incision being made anterior or front of, anterior to or the front of your cervix, and I have had one occasion to remove tubal pregnancy through an anterior colpotomy.

MR. HANNON: Thank you.

BY MR. DOWDEY:

Q. When was that? A. I'm afraid I can't give you a date.

Q. Was it after February, 1955? A. I'm not even sure of that.

Q. Well, if my arithmetic is correct, of the four or five unruptured

tubal pregnancies you had occasion to diagnose and treat up until February, 1955, three or four of them being treated by colpotomy, or excised by colpotomy or through colpotomy, that leaves only one, or at most two, that were treated by laparotomy. A. And I believe my previous testimony will bear that out, that I stated that I could remember but one unruptured that I had removed by laparotomy.

Q. I see. A. The reason for this is simply that the unruptured tubal pregnancy can be diagnosed really only by visualizing it, and this must be done through a colpotomy or with the use of colposcope, or through exploratory laparotomy. Now, if the diagnosis is made by colpotomy, there are those of us who feel if it is readily available, technically this
22 then represents the simplest means of removing same. Furthermore, it means less hazard for the patient, as far as major complications are concerned. It means a much earlier recovery, and perhaps of some importance, a lack of disfiguring scar.

Q. The use of the colpotomy technique, however, is not dictated by emergency conditions, is it? A. Emergency only to the degree that if you suspect an ectopic strongly enough the diagnosis should be established and not waited upon, for rupture of an ectopic can be an extremely serious thing, and if one is conscious and aware of the possibility and actually the probability of the existence of a tubal pregnancy, it is my belief that that diagnosis should be established beyond shadow of a doubt, and that one should not procrastinate in diagnosing. On that basis, emergency to the degree that I do not believe that days should be allowed to interfere.

Q. But hours? A. Hours, yes.

Q. Now, after having observed this condition that you might diagnose as a tubal pregnancy by colpotomy, if in fact after that or about that time a rupture did occur, you would then have to proceed by laparotomy right at that moment, would you not? A. No, the problem is this: that if there
23 is considerable bleeding present, blood already present, bleeding taking place, it obscures through the colpotomy incision the organs, and

one is unable to properly handle the tissues involved and accomplish the surgery, and without danger of misplacing scalpel, sutures, et cetera. It is for this reason that, if there is any technical problem anticipated, that one simply rapidly closes the colpotomy incision and then does a laparotomy.

Q. In other words, if the situation is truly an emergency, you would have to proceed with laparotomy? A. You should. I might add that by the same token it would be wholly unjustified in my opinion to simply, because this pregnancy was an unruptured one, to close the incision, allow the patient to recuperate from anesthesia, and then sometime later do the laparotomy. This would be strictly to the patient's detriment.

Q. In what respect? A. For one thing, the need for a second anesthetic. For another thing, a further delay in definitive therapy. You know what you must do. There is no treatment for tubal pregnancy except surgery.

Q. Doctor, in the four or five instances of unruptured tubal pregnancies that you have described thus far as having diagnosed and treated up to February, 1955, were any of them cases where one tube had already
24 been removed or mutilated or tied off or something like that?

A. To the best of my knowledge, no.

* * * * *

25 Q. The procedure done by colpotomy is, of course, much simpler
26 than the laparotomy, is that correct? A. Simpler if the structures are readily available through that incision, and simpler in the hands of the individual who has been trained to do it. For the average, general surgeon, for instance, this would not be the simplest technique, because it isn't something he has been trained to do.

Q. Well, as regards the two techniques, would you care to compare them, say, as to preparation for surgery and so forth? A. Well, as far as preparation for surgery goes there is no difference. As far as the

operative procedure is concerned I think we have perhaps fairly well covered that difference. The big differences come in the convalescence of the patient, as well as the hazards immediately surrounding the surgical procedure itself. The vaginal approach is safer, as far as major complications are concerned; convalescence is shorter; patients are more comfortable; and of perhaps lesser importance, certainly of lesser importance, the question of visible scar.

Q. Is it safer as regards the risk of infection, Doctor? A. Safer to the degree that in most instances if an infection occurs through the vaginal incision it doesn't, it is not as severe, disabling a thing, or as hazardous from a standpoint of life itself, as an infection occurring in an abdominal incision.

27 Q. Let me -- I think my -- you say that the infection that might result would be less serious, but the chances of infection resulting could be more serious, I take it? A. I don't think that the chances of an infection occurring one way versus the other is probably very much different, if any.

We are talking about removing the unruptured tubal pregnancy. This has nothing to do with the matter of infection itself. Infection is related simply to an avenue being opened by any incision, and infection is always a hazard of any surgery. But the fact that a tube is removed or not during the procedure has nothing to do with whether or not the infection may or may not occur.

If the colpotomy incision is made or if the abdominal incision is made, what you do through that incision will not make very much difference unless you are through, [perforate] let's say the intestine, or the length of the procedure will govern somewhat the incidents of infection and so on. Do I make myself clear?

Q. Perhaps. That area of incision is immediately adjacent to the bowels, is it not? Large intestine, I'll say. A. Well, more specifically the anus itself, is that what you mean?

28 Q. No. A. Then the answer is no, because in abdominal surgery you even have to move bowels out of the way, the rectum goes right by the same area.

Q. I refer to the place of incision during the colpotomy. A. Well, again, your intestines are right beneath your abdominal incision. I'm afraid I may not quite understand your question.

Q. I'm afraid I may not quite understand your answer. A. At any rate, one would actually have to perforate the bowel in order to make any difference in that regard.

Q. Let's go back a little bit to talk about the cul-de-sac, and I think you referred to it as Douglas cul-de-sac? A. That's right.

Q. Tell me what surrounds that cul-de-sac? A. What surrounds it?

Q. Let me now -- I made a suggestion earlier about a little drawing here of the geography of the area we are covering. Would you care to explain this region by drawing, Doctor?

(The Doctor complied with the suggestion.)

Q. That's very good. A. A good start?

29 Q. A good start. A. That will give you some idea.

Q. That's excellent. It's better than the book I have. A. (Indicating on drawing.) Well, this is bladder, this is the rectum, this is a uterus, here.

Q. Let me see if I can make it clear for the record by a description. What you have drawn is a lateral view? A. Hmm mmm.

Q. Of the what would you say, the torso? A. Torso? Let's say the pelvis.

Q. Of the pelvis. Good. It is the difference between a physician and an artist. And could you identify these areas in some way? A. This is rectum.

Q. If you want to strike a line out of here, I have a colored pencil here if that will help you any.

(The witness labeled his sketch.)

A. Good. I think that will be sufficient.

MR. HANNON: Will you read in the record the parts he has identified?

BY MR. DOWDEY:

Q. He has identified on this one, which we shall call the lateral view of the female pelvis region, he has indicated the tube, the ovary, the cul-de-sac, the uterus, the bladder, vagina, and rectum. The last word
30 being the word that I couldn't think of before.

The--reverting to my last question, the cul-de-sac is immediately adjacent to the rectum? A. Immediately adjacent to the rectum, immediately adjacent to the uterus. It is formed actually by those boundaries, front and back.

MR. DOWDEY: Will you mark this as plaintiff's exhibit C, for identification?

MR. HANNON: Duplicate it and make it part of the record.

(The sketch referred to was marked for identification as plaintiff's exhibit C, and is attached hereto.)

Q. Doctor, we have been discussing the diagnosis and treatment of tubal pregnancies. Who are the recognized authorities in this field?

A. On tubal pregnancies?

Q. (Nodding his head affirmatively.) A. I don't know that there are any particular authorities in this particular condition. I think any of the authorities on gynecology throughout the country, throughout the world in fact, would be as well authorities on this particular subject.

Q. Well, it is not an uncommon condition, is it? A. No, it is not uncommon, that's true.

* * * * *

43 A. I would like you to read it back.

(The reporter read as follows: "Decidual tissue is the endometrium, parenthetically, lining of the uterus, which under the influence of the hormones of pregnancy, apparently, specifically progesterone, undergoes specific cellular changes.")

44 MR. HANNON: In connection with the word that you were looking for, that you were bothered with, Dr. Eavey a while back said in connection with surgery via the colpotomy method, when it was bleeding that there was a danger of misplacing a scalpel. Could that have been what you were concerned with?

WITNESS: No, I think that's obvious. We never misplace scalpels. (Laughter).

MR. HANNON: When you use the term "misplacing the scalpel," you mean cutting an area where you shouldn't be cutting?

WITNESS: Yes, simply an area of obscured vision.

MR. HANNON: Good. I was wondering.

WITNESS: I might just add to that last statement then, that these changes may occur regardless of where the pregnancy exists. Unfortunately, the placental tissue with an incomplete uterine abortion on occasions, apparently, may be entirely extruded prior to investigation, and decidual tissue only reported. This may be misleading, inasmuch as it does suggest possibility of tubal pregnancies. I think I'm getting a little bit off course on that.

BY MR. DOWDEY:

Q. I think you have come to the next question. I asked you to describe decidual tissue. My next question was to describe placental tissue. A. Well, I think very simply, placental tissue contains what we
45 know as chorionic villi.

Q. Hairs? A. Not in this instance.

Q. It isn't? A. No, these are multiple little protrusions from the maternal side of the placenta which literally burrow their way into the wall of the uterus, attach themselves, and thereby is set up a pool of blood in and around these things, and the bathing of the placenta allows for transfer of oxygen, nutrition, et cetera, across the barrier.

Q. Doctor, just generally, the signs of the decidual tissue is one of the many sides of pregnancy? A. True.

* * * * *

46 Q. * * *The existence of decidual tissue, Doctor, is an indication of pregnancy, is it not? A. I would have to qualify it. The endometrium can undergo changes which are labeled pseudo-decidual reaction, as a result of the influence, the heavy influence of progesterone, be this of endogenous or exogenous source. This is another source of error in diagnosing tubal pregnancies as a result of a report of decidual tissue.

Q. Let me ask you this again, Doctor. If you find decidual tissue in the womb or in the uterus, that is evidence of pregnancy, is it not?

A. It is except in the instance that I have just pointed out, and a pseudo-decidua sometimes is indistinguishable from true decidua under the microscope. As a result, a report of decidua may not necessarily be conclusive proof.

* * * * *

48 Q. Now, I think we are ready to proceed to the subject of your most recent artistic endeavor, Doctor. Would you mark this plaintiff's D for identification?

(The document referred to was marked plaintiff's Exhibit D for identification, and is attached hereto.)

Q. Would you describe this drawing for us, Doctor? A. The drawing is simply a schematic representation of the relationship of the fallopian tube to the uterus and its cavity. It becomes apparent that there is a continuous cavity from the vagina through the uterus and through the fallopian tube by way of the free opening of the tube into the abdominal cavity. The ovary is adjacent to the tube and represented is the aforementioned narrowing of the tube as it approaches entry into the wall of

49 the uterus.

What else would you like to know in this regard?

Q. Well, let me see. How would you designate the various segments, well, not segments, but the extent of that tube? Are there some labels that you can put on it? What do you call the part where it enters the uterus? A. Where it enters?

Q. Yes. A. This area? (Indicating on Exhibit D.)

Q. That area. A. This is the isthmus, the isthmus and the funnel. This is the fimbriated end.

Q. Fimbriated end? A. Hmm mmm.

Q. Where do most tubal pregnancies occur, in the tube? A. In the ampullary portion.

Q. And is that part, would you say, the third of the tube closest to the fimbriated end? A. That's correct.

Q. And that the widest part of the tube and more or less funneled shape? A. That's correct.

Q. Would that be a fair description? A. Hmm mmm.

* * * * *

51 Q. Well, if you can designate them perhaps in large blocks of numbers? A-1 through A-43 and B-1 through B-5, you are familiar with those? A. Except maybe some dates.

Q. In what respect, I mean, how are you familiar? A. I'm familiar with these because of my having personally taken care of Georgiana Harvey during that period of time.

52 Q. And more recently did you have occasion to review those photostats or similar photostats? A. Yes.

Q. And when was that? Yesterday? Or before? A. Yes.

Q. And did they serve to refresh your recollection about the diagnosis and treatment of Mrs. Harvey? A. Yes.

Q. Would you tell us in your own words what procedure, diagnostic or otherwise, you followed in your treatment of Mrs. Harvey? A. How much detail do you want here?

Q. Whatever you care to give. A. All right.

Q. The floor is yours. A. May I refer for dates?

Q. Oh, certainly. Most certainly. A. If I can find what I want here. Apparently I first saw Mrs. Harvey on the 16th of February, 1955, at which time Mrs. Harvey reported to be 28 years old with three previous

pregnancies, two of which represented early miscarriages, and one a left tubal pregnancy in November, 1953, for which a left salpingectomy was performed by laparotomy. She stated that at that time her last period,

53 her last normal period was about the second or third of January, 1955, and that approximately twelve days prior to this visit she had begun to have low abdominal cramps, the passage of a small amount of bloody discharge from the vagina. She had had marked right low quadrant pain and low back pain two nights prior to being seen, and also reported that she had had two negative frog tests. Her breasts had become more firm, and she had noted some rectal pressure but no shoulder pain. Her periods had been regular every 28 days up until the time of her last normal menstrual period as recorded.

Pelvic examination at the time revealed the uterine cervix to be softened and with a slight bluish discoloration. The uterus was thought to be in anterior position and not enlarged. The right annexa were tender with a suggestion of fullness, but no specific mass was palpable. The left annexa, which by history at this time represented only the left ovary, was sensitive, but much less so than the right side.

Recto-vaginal examination was confirmatory and no crepitus was palpable in the cul-de-sac. It should also be stated that I remember that Mrs. Harvey, when she presented herself, stated that she thought that she had another tubal pregnancy.

54 Mrs. Harvey was advised that she was probably right, and I explained that we would establish diagnosis by means of a vaginal incision, and I'm morally certain that I likewise explained that if another tubal pregnancy existed that, on the right side, that the right tube would almost surely be removed.

Q. I didn't hear that last part. A. I'm sorry. That the right tube would almost surely be removed. Mrs. Harvey was then admitted to the hospital and prepared for surgery, obtaining urinalysis, blood counts, and given pre-operative medication. She was taken to the operating room and

under general anesthesia the vagina and perineum were surgically prepared and draped, the patient in a lithotomy position.

* * * * *

- 56 Q. Would you want to continue with your narrative account? I think I interrupted you or you interrupted it when you couldn't find that operative report. A. The bimanual examination at this time revealed two small masses palpable in the right annexa area. Incision was then made in the--transverse incision was then made in the posterior fornix of the vagina and the cul-de-sac was entered. The right adnexal struc-
- 57 tures were brought down into the incision and the small pregnancy noted in the ampullary portion, distal portion would be right, of the right tube with a small amount of blood oozing from the frimbriated end of the tube. The ovary was normal in appearance. The tubal pregnancy was removed by clamping and ligating the mesosalpinx at approximately the mid-portion of the tube proximal to the tubal gestation. The left adnexa was explored and no tube was present.

MR. HANNON: Doctor, could you keep your voice up a little bit? I'm having difficulty following you.

A. The ovary on the left was normal. The colpotomy incision was then closed with chromic catgut suture. The cervical canal was then dilated with Hegar dilators, and sharp curettage of the uterine cavity executed obtaining a moderate amount of endometrial tissue. The patient was then returned to the -- her bed in the ward and her recovery from anesthesia and surgery was rapid and normal.

She was discharged from the hospital on the 18th of February in apparently good condition.

Do you want me to go right on ahead with the subsequent --?

- Q. Go ahead. A. On the 25th of February, Mrs. Harvey was again
- 58 seen complaining of the sudden onset of severe pain in the right lower quadrant of the abdomen and rapidly becoming generalized. There had been no nausea or vomiting and her last bowel movement was the

preceding day. Mrs. Harvey had been well to this date except for mentioning some vague intermittent right lower quadrant discomfort to the preceding three days. Examination at this time revealed the patient to be in obvious acute distress. Abdominal examination revealed a board-like rigidity of the abdominal musculature without distention and with a few audible bowel sounds. Recto-vaginal examination at this time revealed marked tenderness in the pelvis, including the area of the cul-de-sac, but no mass was palpable. And at this time it was impossible to, because of tenderness, to outline the pelvic structures adequately.

She was again admitted to the hospital, blood counts obtained, plain film of the abdomen--x-ray film of the abdomen obtained which was negative. Blood counts were negative, except for a slightly elevated white blood cell count of 13,900 per cubic centimeter. Surgical--strike that. General surgical consultation was obtained and the possibility of -- strike that. And the diagnosis of peritonitis was made possibly on the basis of post-operative infection, a possible bowel obstruction, and possibly ruptured viscus. It was felt that exploratory laparotomy was mandatory and

59 the nature of the problem was explained to the patient. She was prepared for surgery. Laparotomy performed under general anesthesia, I believe--yes, -- and it was found that apparently a small abscess had occurred in the cul-de-sac which in turn had ruptured into the peritoneal cavity. A [The] procedure of choice was felt to be to drain the abdominal cavity, close the incision, and treat with anti-biotics and supportive therapy. It was felt that the most logical point of drainage would be through the cul-de-sac into the vagina, and this was executed. During the procedure, except for the generalized inflammatory process, the pelvic structures were otherwise normal, including the remaining segment of fallopian tube on the right.

Mrs. Harvey's course post-operatively was satisfactory with one exception. For several days she complained of pain with deep breathing in the right upper quadrant of the abdomen, and the possibility of a sub-

diaphragmatic abscess was entertained. Abdominal x-ray and her subsequent course failed to support this diagnosis.

Abdominal skin sutures were removed on the 4th of March, and on the 7th of March, Mrs. Harvey was discharged from the hospital in good condition.

I should interject here somewhere that after the original operative procedure of the removal of the tubal pregnancy I again, I'm morally certain that I explained to Mrs. Harvey that her right tube had been essentially
60 removed and that for all intent and purposes she would thereafter be sterile as far as childbearing was concerned.

I again saw Mrs. Harvey on the 22nd of March, 1955. At that time she, according to my note, was feeling well except for some generalized abdominal discomfort, some supportive discomfort during urination, and some discomfort with defecation. She had had no vaginal bleeding at that time. Examination revealed her abdominal incision well healed, and bimanual examination revealed minimal pelvic fixation and induration. It was thought that the left ovary at that time may have been slightly enlarged and was somewhat tender.

She was placed on hot vaginal irrigations and hot tub baths, and according to my note advised to return again in four weeks. To the best of my knowledge and with the absence of any further record, this was apparently the last time that I saw Mrs. Harvey, but the note does state that she was advised to return in four weeks time.

I think that covers it.

Q. In the foregoing statement do you believe you have covered all the essential features of the course of your examination, diagnosis and treatment of Mrs. Harvey? A. I believe so. I'm sure that there is some detail which I haven't covered. The essential features, yes.

61 Q. And in doing so you have had before you the medical record of the Air Force? A. Correct.

Q. Which you have gone over the previous day? A. Yes.

Q. And as that record is before you at this moment, do you consider that record complete? A. By "complete" do you mean is this all the record that there is or was?

Q. Is this all the record that there should be to cover the examination, diagnosis and treatment of Mrs. Harvey as far as you are concerned? A. I believe so.

* * * * *

62 Q. Doctor, the City of Washington is a large, metropolitan community, is it not? A. Yes.

Q. And standards of practice are rather high, would you say, as regards obstetrics and gynecology?

MR. HANNON: I object. It calls for a conclusion of law.

63 MR. DOWDEY: Will you answer?

MR. HANNON: You can answer, yes, sure.

WITNESS: Okay. I didn't know where I stood. Yes, I think so.

BY MR. DOWDEY:

Q. Now, within your own, is it branch of the service, what do we call it -- within the Air Force in that vicinity, what other Air Force establishments do they have that have a gynecological service? A. At that time, none.

Q. None other than Bolling? A. That's correct. Hmm mmm.

Q. Is Bolling used by any other branch of the Armed Forces than the Air Force? A. Yes, by the Army, and very occasionally by the Navy.

Q. Now, let's take them up. What Army medical facilities were there in the Washington metropolitan area that had a gynecological service? A. Walter Reed General Hospital, and I guess you could include Belvoir Army Hospital, I don't know what name they give to it.

Q. How about the Navy? A. Bethesda Naval Hospital.

Q. As regards Walter Reed and Bethesda Naval Hospital, are they not very large medical centers? A. They are.

64 Q. Would you say that they are the major medical centers in the Armed Services? A. In that area?

Q. Anywhere. A. The largest.

Q. The largest and the most extensive staff? A. I don't know that to be true. The Army, for instance, has several very large installations. Brooke General at Fort Sam Houston, for instance, conceivably may be bigger than Walter Reed.

Q. I really don't know. In other words, it is very large and certainly it is not the largest one of the lot, is it? Do you know what kind of a gynecological staff they had at Walter Reed at this time in February 1955? A. The only man that I knew at that time was Colonel Riva, head of the department.

Q. Colonel who? A. Riva, R-i-v-a, and other than knowing Dr. Riva I had no intimate knowledge of his department.

Q. What was it or was it not a rather large, well-staffed department? A. Oh, I think so.

Q. Would you say the same with respect to the Naval Medical Center at Bethesda? A. I would.

65 Q. And in addition to that there are other large medical institutions in the metropolitan area, are there not, that have extensive staff in gynecology? A. True.

Q. And what are some of them? A. This would be pretty well covered by simply mentioning the institutions of George Washington, Georgetown University I think, as most men are associated in one way or another with those departments.

Q. Would it be fair to say that in such community there would be available to you for discussion, consultation, many superlatively well-qualified specialists in gynecology? A. I'm not quite sure by what you mean by "available".

Q. Well, that were there, let's take it that way, that were there and present in this community? A. Actually, as far as formal consulta-

tion was concerned, one could refer a patient to another one of the armed forces installations where we had, each of us, one or more civilian consultants who were specifically to be utilized if we wanted them.

Q. Would that qualifi----- A. These people -- excuse me -- these consultants were named and paid by the Air Force.

Q. With that qualification on my use of the term "available" your answer to my question would be yes? A. Well, I think I have answered the question.

Q. A qualified yes? A. Qualified with respect only to the use of the term available.

Q. Available. Unh-unh. Did you know personally any of these gynecologists? Know them well? A. Yes.

Q. Many of them? A. Again we come to a definition of terms. How many is many?

Q. Well, how many did you know? A. Well, knew well probably not more than five or six.

Q. And were these gentlemen available for consultation? A. Only through informal consultation by phone. Now, the one man, of course, was our specified civilian consultant, and he was available for formal consultation at any time.

Q. But not informal? A. Oh, he was available for both formal and informal, but the other man would be available.

67 Q. Do you remember his name? A. Dr. Stafford W. Hawken, H-a-w-k-e-n.

Q. Was he consulted in this case? A. Not in this case.

Q. Was anyone consulted in this case? A. In the original diagnosis and procedure?

Q. Yes. A. No formal consultation.

Q. What part did Lieutenant -- what's his -- is it William Johnson? A. Johnson.

Q. Lieutenant William Johnson, I guess it is, play in this examination, diagnosis and treatment of the ectopic pregnancy, a tubal pregnancy of Mrs. Harvey? A. Dr. Johnson was a member of my staff and assisted me in surgery, post-operative care of the patient.

Q. Did he participate in any way before the surgery? A. Not from the standpoint of establishing, number one: diagnosis; or, two: disposition of the case. This was my responsibility.

Q. Did he see the -- Mrs. Harvey, before the operation? A. Before surgery? Yes, I'm pretty sure, I think the records will disclose this, that he actually did her history, pre-operative [history] and physical ~~history~~ [examination].

68 Q. When would he have done that, before you saw her or afterwards? A. After I saw her.

Q. Afterwards? A. Hmm mmm.

Q. So, when you saw her you did not have a history and physical? A. I saw her in the out-patient department.

Q. When she first came to the hospital and presented herself, as you say, you were the first -- A. Exactly.

Q. -- you talked to her and examined her? A. Right.

Q. And you wrote a note on that and made a tentative diagnosis, and then Dr. -- A. Johnson.

Q. -- Johnson took the history and the physical, is that correct? A. Once she was admitted to the hospital, that's correct.

Q. And then, is that the first time you had seen Mrs. Harvey, on that first admission? A. Yes.

Q. 15th, February? A. Yes.

69 Q. How soon thereafter was the operation performed? A. I would have to refer to records as to actual time --

Q. Will you? A. -- elapsed, and I may not be able to tell then. (Searching.)

Q. Without looking at the record could you give an estimate of time? A. A matter only of several hours would be my guess. (Searching.) The record does not indicate at exactly what time of day I first saw Mrs. Harvey in the out-patient department, but it is my assumption that the time lapse was simply a matter of obtaining the necessary laboratory work and getting the patient prepared for surgery, and therefore at best would be in the neighborhood of two to three hours.

Q. You mean when you say "at best" -- A. At most --

Q. It likely would take longer? A. I would say at most it was probably no longer than that.

Q. No longer than two or three hours? A. It might have been shorter, possibly.

Q. Between the time of your first examination, when she first presented herself and when you saw her, did you see Mrs. Harvey again until you saw her in the operating room? A. I can't answer that.

70 Q. You don't recall? A. I don't recall, that's right.

Q. Do you recall what you may have done with respect to this case during the two or three hour estimated interval between the time you saw her, between the time you first saw her, and the time that you saw her in the operating room? A. Well, the things that were done were those of seeing to it that the pre-operative orders were left, seeing to it that laboratory work was done, that the operating room was

notified, and that the general routine history and physical examination, which of course would have to include pre-operative heart and lung examination et cetara, would be done by a member of my staff, and I assume that I took care of notifying, in this case, Dr. Johnson.

Q. Well, those are largely administrative duties -- A. Exactly.

Q. -- that you would delineate, right, or did you? A. I'm not sure what you are driving at.

Q. I don't think you are sure what I am driving at, but I'm asking the question of what you did with respect to this case during the interval,

71 two or three hours, from the time you first saw Mrs. Harvey until you saw her again in the operating room? What you did? A. In the way of treating her, or what?

Q. Did you do anything other than take care of the administrative tasks you have just described? A. With respect to this case?

Q. Did you work on other cases? A. I'm sorry, but I can't recall that. I may very well have, as far as the out-patient department was concerned, I may have seen other people there in the interim, very possibly. I don't know.

Q. Well, did you prepare for surgery? A. Did I prepare for surgery?

Q. Yes. A. I scrubbed, if that's what you mean.

Q. How long did that take? A. Oh, it's usually about a ten minute procedure.

Q. And other than the administrative tasks that you have outlined, and prepared for surgery, do you know of anything else you did during that time? A. I can't recall anything else.

Q. Would you ordinarily have done anything else with respect to this type of thing? A. Under such circumstances, once a decision has

72 been made and the situation explained to the patient, normally there is nothing else to do, no. Except the administrative things that

we have already covered, and of course reviewing those, the studies obtained, and so on.

Q. How long did the operative procedure that you employed take? A. My I refer to record?

Q. Sure. A. Okay. (Searching.) Including pelvic examination, the entire procedure, just about one hour, according to the anesthetic record.

Q. I didn't hear that. A. According to the anesthetic record, about one hour.

Q. About one hour? A. That's right.

Q. When did you receive the pathology report? A. That I cannot recall.

Q. Could you give us an estimate? A. Well, the typewritten report was probably not received until about a week to ten days. That's probable.

Q. Did you have some word on it before then? A. I cannot recall.

Q. When did you next see Mrs. Harvey?

MR. HANNON: Next when? From when?

73

BY MR. DOWDEY:

Q. After the operation. A. Well, very likely that same afternoon, after surgery, although again this not being a matter of record, to the best of my knowledge I can't be sure. This would be normal procedure.

Q. And when after that? A. Every day, probably.

Q. Once a day while she was in the hospital? A. Me personally, yes, although she was being seen twice a day either by me or members of my staff. At least twice a day.

Q. While she was there? A. Yes, sir.

Q. Would you describe for us just briefly, Doctor, what you mean by a pelvic examination? A. Yes. Pelvic examination includes pretty

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A. It depends on the status of that ectopic pregnancy.

Q. Yes. A. If there has been massive bleeding into the abdominal cavity it is a relatively easy diagnosis. If it is early ruptured or merely leaking blood into the tube it is a very difficult diagnosis many

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Q. But it resembles many other things, does it not? A. It surely does.

Q. Many things in many different fields? A. I wouldn't -- well, go ahead.

MR. HANNON: May I ask which resembles many things, the ectopic pregnancy with profuse bleeding or the ectopic pregnancy with sparse bleeding?

THE WITNESS: The ectopic pregnancy with less or sparse bleeding.

BY MR. DOWDEY:

Q. And that was the situation here, was it not? A. Exactly.

Q. Would you say that persons who suffer an ectopic pregnancy on one side frequently repeats on the other? A. Unfortunately, again we are dealing with a word that may be a little misleading. "Frequently".

I can't give you any percentage, but at any rate it is not uncommon for it to occur on the opposite side at a later time. As a matter of fact, there have been those who have even proposed that if an ectopic occurs on one side and the other tube is in any way damaged that prophylactically it should be removed. This I think is surely in the minority of thinking, but anyway it suggests the problem involved.

77 Q. Is there not -- are there not plastic surgery techniques available to remedy any defects in fallopian tubes? A. This is with, then, with specific regard to the presence of tubal pregnancies, is this what you are asking?

Q. No, I'm just asking the general question. A. Oh, the general question. All right, yes, there are such procedures.

Q. And what are they, just very generally? A. Well, basically it depends on where the disturbance in the fallopian tube is, but all of them boil down to re-establishing potency of that tube. It may be a simple matter of circumcising the end of the tube, if most of the tube is healthy except its outer end, which has been clubbed and closed. By circumcising, I mean simply cutting it off and simply pinning the edge of the mucosa back. If the obstruction is in the isthmic portion of the tube the usual type procedure is to incise the tube distal to the obstruction, creating a window in the myometrium (the wall of the uterus), and tuck the freed outer portion of the tube in such a manner that it is now proximal and fits into this window in the uterus. In cases where tubes are nonexistent the procedure has been utilized wherein the ovary is literally buried into the wall of the uterus in such a manner that the one surface of the ovary protrudes into the uteri cavity.

78 Q. You indicated earlier that none of these procedures was relevant to this case. A. No, I was asking specifically whether this was what you meant.

Q. Well, are they relevant to this case? A. There are times

and where, if a tubal pregnancy is in the judgment of the operating surgeon considered to be early enough and small enough, that an incision can be made over the pregnancy, the pregnancy shelled out of the tube, and the tube reclosed. This obviously is slightly different in its plastic connotation than are the procedures which are designed to correct an occlusion appearing in another fashion.

Q. Oh, one other thing, Doctor. You have used the word adnexia -- pardon, adnexa. A. That's plural, by the way.

Q. Yes, frequently, and you refer do you not to the fallopian tube and the ovaries? A. This is ordinarily adnexed, we might say, to the uterus, that's correct.

Q. Adnexed; adnexation might be a looser way of expressing it.

MR. HANNON: Is there a question pending the Doctor hasn't answered?

79 MR. DOWDEY: It's a leading question.

MR. HANNON: I'm talking about the question prior to that. Did you ask whether or not these procedures for plastic surgery for shelling out the ovary egg is applicable in the Georgiana Harvey case? If you did ask it, I don't think it has been answered.

MR. DOWDEY: I think he answered it.

THE WITNESS: I stated that if in the judgment of the surgeon -- this immediately infers that this was not my judgment, sir.

MR. HANNON: All right. So long as it is clear on the record.

BY MR. DOWDEY:

Q. It was a possibility, however, was it not? A. I think we always must consider such a thing, but again it is unfortunate or rare to pick up a pregnancy so early in the tube, and a pregnancy that has markedly distorted and damaged the tube. You are just up against a practically impossible situation.

MR. HANNON: Again, in order to clear the record, I hate to do this -- you say the tube is markedly distorted. Was this Georgiana Harvey's situation?

THE WITNESS: In my judgment, yes.

MR. HANNON: I didn't mean to do this to you.

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BY MR. DOWDEY:

Q. The exercise of his judgment, of course, assumes that there is a possibility, is that correct? A. Well, again, I think that this always has to be a part of our thinking any time we approach this situation.

Q. Did you at any time discuss this possibility with Mrs. Harvey, the possibility of plastic repair of the fallopian tubes? A. I cannot honestly recall. Very likely, inasmuch as it is my normal procedure to do so. And having left a small portion of tube this possibility was likely held out to her, but likely was discouraged, primarily because of her experience up to this point. It is one of the things you do with any plastic surgery on a tube ~~and you do immediately~~, for if this patient conceives her chances of having another tubal pregnancy are far greater than that of the average population. Average female population.

Q. Doctor, away back on this -- will you read that to him? I think he has answered several questions there.

(The question beginning at Line 5 above, and the answer beginning at Line 8 through Line 16 above, were read.)

Q. Do you want to amend that in any respect?

MR. HANNON: May I say this for the Doctor's benefit. The stenographer will be able to keep up with you. Apparently what you might be doing is intentionally answering slowly so she will be able

81 to keep up with you. If you look at Mr. Dowdey when you answer, I think --

BY MR. DOWDEY:

Q. Well, let me straighten it out. The only discussions of plastic surgery of the tubes that you may have had with Mrs. Harvey if at all, was after the operation, is that correct? A. I would think so. I would think that in my original discussion that I would not have tried to hold

out to her at that time the hope of preserving her child-bearing functions. I think that this would be unfair optimism.

Q. You mean after you had operated on the tube? A. I think your question read, did I at any time before surgery discuss this possibility, and my answer is that I likely did not for the reasons that I have mentioned.

Q. But that you may have discussed it after surgery? A. May, yes. But I am sure that I told her that for all intent and purposes she would have to consider that her chances of getting pregnant were, oh, extremely unlikely.

May I take a break for a moment and make a phone call?

Q. Sure.

(Short recess.)

82 Q. Doctor, do you have an opinion about the life of the aborted tubal pregnancy you excised, how old was it? A. Based on really, primarily, on the patient's history and the fact that size of the pregnancy was compatible at least with this history, pregnancy, conception I should say, likely occurred about mid or late mid-January, and that therefore, roughly, the gestation was of four to five weeks duration.

Q. Now, that's about as early as they are ever discovered, is it not? A. No, they are picked up sooner than that, sometimes three weeks, and of course the distortion of the tube is not necessarily related to the duration of the pregnancy, if there's hemorrhaging into the wall of the tubes and such this likewise is a big feature.

Q. I appreciate there are other matters involved. A. Right.

Q. But I say, this is about as early as that would be found, within a week or two? A. Not many found much earlier than that, that's true.

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83 Q. Let me ask another broad question. Could you discuss just briefly the histology of tubal pregnancies? A. The histology of tubal pregnancies is most often characterized by the presence of decidual and

placental tissue, but very often the pathologist will report only those things which label the structure as a hematosalpinx.

Q. And what is that? A. In such instances there will be merely the swelling of the tubal walls with extravasation of blood and fiber
84 into its substance and inflammation of exploratory cells. This probably in some instances is true because of expulsion of the products of conception through the end of the tubes, and very often because of their minute nature these structures are never encountered by the surgeon. I think that answers it. One might include the presence of blood clot in the tube, itself.

Q. Isn't the presence of clots or clot and perhaps secondary hemorrhaging one of the difficulties presented to a pathologist in making -- A. As far as --

Q. -- and evaluating? A. As far as evaluating the histological picture it certainly is, yes.

Q. And this problem arises even in those tubal pregnancies where there is no rupture? A. Yes.

Q. And histology, therefore, is difficult? A. No apparent rupture.

Q. No apparent rupture. Histology, therefore, is difficult, is it not? A. Yes, can be.

Q. And microscopic examination is frequently unrewarded? A. I would say not frequently, but it is sometimes, yes.

85 Q. Oh, one other thing, in fairness to you I perhaps should have brought it up. Would you discuss just briefly what an ectopic pregnancy is, and then what a tubal pregnancy is? A. Well, by definition an ectopic pregnancy is any pregnancy which occurs beyond the confine of the endometrical cavity. A tubal pregnancy is a type of ectopic pregnancy which grows in one or the other fallopian tube, tubes.

Q. What are the dangers of tubal pregnancies? A. The prime danger is one of intra-abdominal hemorrhages and all of its sequelae. Would you like me to elaborate on the sequelae?

Q. No, the sequele I think we all understand. Is there any other danger other than hemorrhage? A. For all intent and purposes, no.

Q. Well, somewhere in here I think I have a note about sepsis.

A. Well, again, this is, I think a sequel of the hemorrhage.

Q. Perhaps I cut you off too soon. A. I believe that when sepsis occurs it is a direct result of hemorrhage.

86 Q. One other thing. I think you touched on this, but does it not happen that on occasions where the fallopian tubes have been severed or tied off that recanalization occurs? Would you like to make a comment in respect to that? A. Yes, this is true, and is even true when the so-called complete removal of the fallopian tubes have taken place. In other words, the portion of the tube even that exists within the wall of the uterus may recanalize and repeat tubal pregnancies on the same side have been known to occur even when total tube has been removed. This has likewise been known to occur when sterilizing procedures have been utilized in which portions of segments of tubes have been removed and their ends ligated.

Q. However, this is not a strong possibility in many cases?

A. Not a strong possibility, no.

Q. And I believe you indicated as much to Mrs. Harvey? A. Yes, I am morally certain I did, yes.

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87 Q. Now, 2-B concerns the continual pain and bleeding and consequent emotional disturbances. I would like to direct your attention specifically to that part of this answer which reads: "In September of 1956, she was treated at Eglin Air Force Base Hospital for what appeared to be a miscarriage, and was so diagnosed there by Dr. Shector."

Is this statement, which you may assume is true, consistent with your examination, treatment and prognosis with respect to Mrs. Harvey?

A. It is possible that she had another pregnancy and had a miscarriage. I think we have already mentioned this as an outside possibility.

But according to this statement there is nothing that shows in any conceivable way that she had such a miscarriage.

Q. I simply asked you to assume the truth of the statement.

A. Assuming the truth of it, I can only say as I have before stated that, sure, it is a possibility.

88 Q. And in what way could that occur, having observed her condition surgically on two occasions prior to this? Could you venture an opinion as to how this might occur? A. Well, the most likely way would be through recanalization of one or other of the tubal sites.

Q. Absent that, could it have occurred? A. According to the best medical knowledge, no.

Q. Now, the -- you did not excise the entire tube, did you?

A. That is true.

Q. There was a substantial portion of it remaining, would you say? A. Yes, possibly in the neighborhood of a third or half of the actual length of the tube.

Q. I direct your attention now to the plaintiff's answer to 2-C, in parenthesis, and particularly noting that in the spring and summer of 1957 according to the interrogatories, Mrs. Harvey was treated by Dr. J.C. Wilson of Ft. Walton Beach, Florida, for what clinically appears to be a miscarriage at about four weeks. Would you care to comment on this, assuming the truth of it? A. Again, assuming that this actually occurred, the answer would have to be the same, possible yes, probably no.

Q. Would you suggest that the appearance of a miscarriage in September of 1956 and the summer of 1957 might have been erroneous?

89 A. They might have well been.

Q. And what condition might, might have produced a similar appearance?

MR. HANNON: May I make an objection, now. And I leave it to the Doctor's judgment whether he wants to -- I object to it because you are asking him about something he has no knowledge of, no personal knowledge of, and for that reason your answer assumes something to be true, and now you are calling on his expertness as a gynecologist to answer the question, and he is not here as an expert witness, and for that reason he doesn't have to answer the question, and I don't think he should be asked for that reason. However, if he feels in his own judgment that he wants to hazard an answer or speculate what the answer to that question might be, if he feels he wants to do it, he can go ahead and do it. I think it is an answer to a question that calls for an expert, and he is --

MR. DOWDEY: Isn't he an expert?

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MR. HANNON: I'll agree that he is an expert.

You may not want to.

MR. DOWDEY: Okay.

THE WITNESS: I don't really mind answering. Without giving every possible reason for such a diagnosis, to state it simply, any woman in menstrual age may have a delay in onset of menstruation for various and sundry reasons, and then have the onset of either, one: a fairly heavy menstrual flow, or two: a prolonged menstrual flow, and have some small changes in the uterus, such as seeming slight enlargement, seeming softness, and have it appear that she may have an early miscarriage, but unless these changes are extremely pronounced or unless there has been actual tissue obtained that has been expelled by the uterus or through curetting, the diagnosis of abortion or miscarriage is not conclusive. Does this answer your question?

BY MR. DOWDEY:

Q. Well, I think so. Let me state it this way, Doctor, if according to the record two physicians with knowledge as indicated by their reports of the removal of these tubes were so bold as to say that their

examination indicated what appeared to be a miscarriage, certainly this is an unusual thing, and I was just wondering whether or not you could offer some explanation? A. I did.

91 Q. And I think attached to the interrogatories that Mr. Hannon showed you is the report of Dr. J.C. Wilson, in which Dr. Wilson regarded it as rather unusual.

MR. HANNON: Is that a question?

Q. Did he not? In that report? A. Dr. Wilson states that this is very difficult to understand in view of her history of having both tubes removed, and I'm sure he considered it unusual just as I did.

I would not, in line with Mr. Hannon's objection state that. Of course, I have no way of knowing how certain either of these physicians were of their diagnosis. In the answer to 2B of the interrogatories, I believe the wording is "what appears to be a miscarriage". I have no way of knowing what conclusive evidence either physician had.

Q. Well, I'd -- A. And still, I would have to admit that the possibility existed that their diagnoses were correct.

Q. Would there be another explanation, other than recanalization for the appearance of a miscarriage as noted by these physicians who were plainly reluctant to believe it? A. If these were definitely miscarriages I see no other explanation.

* * * * *

92 Q. I direct your attention now, Doctor, to paragraph, answer 2-E, in parenthesis, which refers to February of 1958, plaintiff advises being treated by a Dr. Frederick Braden in Pensacola, and I refer you to the copy of Dr. Braden's report attached to the interrogatories, and ask you if in connection with your examination and diagnosis or treatment of Mrs. Harvey in February in 1955 for a tubal pregnancy, shortly thereafter of peritonitis, the two instances of what appears to be miscarriages, one in 1956 and one in 1957, and this report of Dr. Braden to Dr. Vaughn, do you have any explanation?

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93 Q. No, no, I didn't. I just say, would you have an opinion as to the cause of whatever disease she may have had according to this report of Dr. Braden in February, 1958, as to its course -- A. Course?

Q. As to its course and development in the light of your two surgical experiences and the intervening history of two instances of what appear to be miscarriages? A. Well, in answer to the first part of that question: it is possible, not necessarily so, that the chronic infection which is herein mentioned dates back to her complication of infection following the colpotomy and removal of tubal pregnancy.

94 Now, as to any association of this diagnosis with whether or not she may have had miscarriages, it does not rule out the possibility that she did -- does not even rule out the possibility they were miscarriages. In fact, infection as recorded here may have originated at the time of the so-called miscarriages. These are possibilities. The origin of the infection as encountered by Dr. Braden, which is as stated a chronic infection, does not in any way specifically label its onset.

Have I answered your question fully?

Q. Well, I suppose so. I would think, however, that this whole matter would be rather remarkable from her discharge from Bolling onward, and I was wondering if we could have some statement, some opinion that might reconcile the whole package. A. Well, I think I have done that.

Q. Would you consider that the events that followed were remarkable? A. If by "events" you mean the miscarriages, the purported miscarriages, yes, I think that remarkable.

Q. And the events of the matter disclosed by the hysterectomy in February of 1958, would you consider that also remarkable? A. No, I would not.

Q. You think that might be a normal consequence?

95 MR. HANNON: Of what?

Q. Of the surgery performed by you? A. A normal consequence, a possible consequence, I should say, of the complication of infection.

Q. That follows here? A. That followed the surgery.

Q. And all in all, then, taking the two remarkable instances of what is said to have occurred, like a miscarriage, two miscarriages, and this matter that happened upon hysterectomy in 1958, could you as an expert give us any explanation, any over-all explanation that would reconcile all of these facts into one logical pattern? A. I'm still not sure just what you are driving at. The infection occurred, and the tubes had been rendered almost surely, almost surely, functionless. The occurrence of any pregnancy thereafter would not be impossible; [but] would certainly have to be considered remarkable. The diagnosis made by the operating surgeon in 1958 is compatible with a ~~beginning, is-~~ ~~compatible with~~ having its beginning either at the time of the post-operative peritonitis or really at any subsequent time. The diagnosis made by the operating surgeon in 1958 does not in any way further remove the possibility of two pregnancies having intervened.

If the question arises that Mrs. Harvey was able to conceive but miscarried, attention is brought to the fact that she had had two mis-

96 carriages prior to first seeing me in February, 1955.

Q. Is it possible that some of the things disclosed by Dr. Braden's report existed prior to your surgery in February, 1955? A. To a microscopic degree, definitely positive -- possible. I'm sorry. As heretofore mentioned, infectious processes involving the fallopian tube is perhaps the major cause -- strike "perhaps" -- is the major cause of the occurrence of tubal pregnancies. The descriptions of small follicular cysts of the right ovary in Dr. Braden's report is of no consequence, inasmuch as every normally functioning ovary will have a very small follicular cyst. And the diagnosis of chronic cervicitis is almost invariably noted any time a cervical tissue is submitted to the pathologist.

Q. How large an incision did you make for your colpotomy?

A. Well, based on the average one that I would make I'd guess about four centimeters.

Q. Four centimeters? I think I have all my questions.

CROSS EXAMINATION

BY MR. HANNON:

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99 Q. Well, is the possibility remote or otherwise that she left Bolling Air Force Base Hospital in 1955 with an inflammatory disease of the pelvis, if her peritonitis condition had been cured with antibiotic drugs? A. Well, to the best of my knowledge and with the evidence we had, the active infection had been cured. That relates to not only the peritonitis but any other inflammation.

Q. All diseases that might exist in the abdominal areas?

A. Active infection, yes.

Q. Now, these two miscarriages that she subsequently had, could they be a source of, of chronic pelvic inflammatory disease? A. Could be.

100 Q. Is there any way that, to your knowledge, either Dr. Braden or any other doctor could determine at the time a hysterectomy is performed first, the source of the disease, and secondly, the duration of the disease? A. Not with any certainty.

Q. Now, Mr. Dowdey asked how much of the tube was excised and followed it by saying it was a substantial portion left. How long is a fallopian tube, generally speaking? A. Approximately it is -- they vary considerably in length, but I would say average approximately three inches.

Q. What, then, would be a substantial portion as was left in Mrs. Eavey, excuse me, in Mrs. Harvey? A. To the best of my recollection, in the neighborhood of an inch to an inch and a half.

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Q. Would you describe, Dr. Eavey, if you can remember Mrs. Harvey's attitude prior to the time that you performed this operation for her tubal pregnancy, and her attitude after it was done, and her
101 attitude at the time she finally left the hospital?

MR. DOWDEY: I don't know. Might as well object to "attitude." Unless he is a psychiatrist and can answer any question.

BY MR. HANNON:

Q. Do you understand the question? A. I understand the question.

Q. Will you answer it? A. Well, when Mrs. Harvey first presented herself as I have heretofore mentioned, stating she probably had another tubal pregnancy, she was most cooperative, seemed to have excellent insight as to the nature of the problem of tubal pregnancies, and accepted very readily the explanation of what was to be done. After surgery, I suppose the word would be "thrilled", Mrs. Harvey was thrilled at the thought of having had her problem corrected without another abdominal incision, and thrilled at how readily she recovered. Now, Mrs. Harvey was obviously most chagrined as were all of us when some ten days later the complication of peritonitis became apparent, and still following her laparotomy she remained a most cooperative and nice individual, and seemed to comprehend the problem of infection and the fact that it is a constant hazard to any form of surgery. At no time do I recall her being upset or displeased with her medical care.

Q. Did she at any time during the first operation, at the time the
102 tubal pregnancy existed, indicate to you concern or alarm because this was now her second tubal pregnancy, that she would be unable to bear children? A. To the best of my recollection this was mentioned to her before the original surgery, and I think I would recall an abnormal reaction, and therefore I assume she was upset by the fact that her child-bearing function would likely be ended, this certainly is the completely and expected normal reaction from a woman.

Q. That brings me to this question. In the event it had been possible to preserve Mrs. Harvey's pregnancy in February, 1955, would you have done so? A. Preserve her pregnancy?

Q. Yes, we have talked about transplanting or shelling the fertilized egg from the tube to the uterus. A. No, I think you are mistaken. The idea would not be to preserve the present pregnancy involved. This could not be done. The question involved was her future child-bearing function might be preserved by such a plastic procedure.

Q. That would be by repair to the fallopian tubes? A. That's right.

Q. Was there any possibility that this method could have been put into effect with respect to Mrs. Harvey's tube, the right tube? A. Well,

103 I think as I have previously stated, in my judgment at the time this was not a possibility and not warranted.

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104 Q. Well, did you have occasion to, during both examinations, to
105 examine Mrs. Harvey's ovaries? A. Yes.

Q. Were they normal? A. Normal except for the fact that in all probability, though I can't be sure, the left ovary was somewhat stuck in its position with a few adhesions, and so forth, because of previous procedures, but as far as being any gross abnormalities, no.

Q. So what about the uterus? A. None.

Q. So at the time you saw no reason or cause for removing the uterus? A. I did not.

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106 Q. You indicated that ruptured ectopic pregnancy was not difficult to diagnose? A. Ruptured to the degree that there is frank and massive intra-abdominal hemorrhage.

Q. On the other hand, an ectopic pregnancy, or more particularly one tubal pregnancy, is extremely difficult to diagnose, is it? A. A tubal pregnancy that has either not ruptured or has done very little bleeding into the abdominal cavity is more often difficult to diagnose.

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107 Q. At the time -- it will be in this record, too. At the time that you performed the initial surgery, Dr. Johnson assisted, is that correct? A. According to the records that's true.

Q. Was he aware of the fact that she had a tubal pregnancy?
A. Yes, and has made note accordingly.

Q. When a woman has a tubal pregnancy what alternative does the doctor have in respect to how he goes about treating her? Are there any? A. If he establishes such a diagnosis, the only course open is surgical, in most instances requiring the excision of the fallopian tube, partial or total, or as previously mentioned in testimony, the circumstances where the pregnancy may be shelled out of the tube and the tube allowed to remain as a possibly functioning structure.

Q. But at any rate, the only alternative is to remove the pregnancy in one fashion or another? A. That is correct.

Q. That's the only questions I have.

REDIRECT EXAMINATION

BY MR. DOWDEY:

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108 Q. All right. Now, the procedure, then, for plastic repair, were it undertaken in Mrs. Harvey's case, would be by laparotomy? A. That is true.

Q. Had you foreclosed the possibility of plastic repair before colpotomy? A. No.

Q. When you made the incision by colpotomy was that still a possibility? A. Yes.

Q. A definite, real possibility? A. Well, it is not often a possibility at that time, but still a possibility.

Q. It is not a possibility, but it is a possibility? A. It is not often a possibility.

Q. It was a possibility before you made that incision, was it not?

109 A. It was.

Q. And a definite one? A. Yes. But, I would add that the colpotomy decision was made originally as a diagnostic procedure. The decision to complete the operation through the colpotomy was made after the organs were inspected and at any time if it had been justified in my mind I could have completed the operation by laparotomy, and I have already intimated this is really more often done than not.

Q. In other words, right there, without any, no anesthetic or anything else, you could sew up the incision? A. I beg your pardon. This is under, all done under anesthesia. The colpotomy is done under anesthesia.

Q. I said -- well, perhaps I proceeded too fast, but let's put it this way, that the colpotomy being basically a diagnostic procedure, had it indicated in your judgment, had you decided after observing things that to undertake plastic repair you could then without a new anesthetic have sewed up your incision in the vagina and simply proceeded then by laparotomy without any -- A. That is true.

Q. -- great difficulty? Right? A. That is correct.

110 Q. Now, in the course of appraising Mrs. Harvey's attitudes, I wonder if you took into consideration the nature of the ectopic pregnancy that she had previous to your examination? A. I'm not quite sure what you mean.

Q. Well, when you undertake to appraise attitudes you run into this problem. Had you questioned the nature of the ectopic pregnancy that she had? A. What do you mean?

Q. Previous to the one you diagnosed? A. What do you mean by the nature of it? A. Well, what was the nature of it, do you know what kind of an ectopic pregnancy did she have before? A. A tubal pregnancy.

Q. Ruptured or unruptured? A. I have no knowledge of this.

Q. Well, there's a big difference, isn't there? A. Not in ultimate treatment there isn't.

Q. As far as the patient is concerned there is a big difference, isn't there? A. As far as the symptoms that she had?

Q. Yes. A. There may be, yes.

Q. A ruptured ectopic pregnancy is a pretty grim experience for a patient, isn't it? A. Usually, yes.

111 Q. With severe pain? A. Usually.

Q. Unconsciousness? A. Maybe.

Q. Yes. Did you know or did you inquire, or did you discover that may have been the case of her previous ectopic? A. I can't recall. It is not in my record and I honestly don't know --

Q. May I remind you -- A. -- the severity of her situation.

Q. -- Doctor, that her attitude is not in your record, either?

MR. HANNON: I object to the comment and move it be stricken.

A. It may not be in the record, but I have specific recollection of certain bits of attitude by this patient. Now, I have some specific recollections of these things. Other things I do not have. I think that that is not difficult to understand that five years having elapsed that there are certain things that I would not remember. Some things I would simply because they stick out for one reason or another. I don't think that contradictory.

Q. Well, I will say this, if you undertake to consider her attitude and express an opinion thereon, would you or would you not consider
112 it relevant as to the type of experience she had had with ectopic pregnancy previous to your examination? A. Her attitude in regard to fear of a similar experience?

Q. Yes. A. Surely, and again I am reasonably certain that she was fearful because she got in early with symptoms which were simulating symptoms which she had experienced before. Sure she was fearful.

Q. Well, when you say in your testimony, Doctor, that after your surgery she was, to use your language, "thrilled", might that be in contrast with her previous experience with a ruptured ectopic pregnancy?

A. It might be in that regard. It likewise might be in regard to the convalescence from the two different types of surgery.

Q. And in any event you didn't feel it necessary to appraise her emotional condition or attitude as you call it, you didn't think it necessary to inquire into the type of experience she had had with respect to the previous ectopic? A. I perhaps did. I honestly don't know.

Q. Do you know if in her conversations when she is referring to an ectopic pregnancy, and you are referring to an ectopic pregnancy, that you were even talking about the same things? A. We were talking

113 about the same things all right.

Q. She was talking specifically about her prior experience, wasn't she? A. True.

Q. And you were talking about your experience with others and with this specific one that you were then treating? A. Yes.

Q. Hmm mmm. Now, you say, Doctor, that in your judgment plastic repair was, A: not justified; B: not a possibility; C: not warranted. I assume that although not justified, not a possibility, and not warranted are strong terms, you admit of the possibility of some other gynecologist disagreeing with you?

MR. HANNON: I object to that. Anything is possible.

MR. DOWDEY: Well, he said it was not a possibility here.

THE WITNESS: The -- this --

MR. HANNON: He is only expressing his judgment.

THE WITNESS: -- is in my judgment.

BY MR. DOWDEY:

Q. And you assume -- A. And in my mind this should not be done.

Q. But, if someone else differed with that judgment you would not regard that as incredible, would you? A. Regard it as incredible?

114 Q. Regard it as incredible. A. I never regard it as incredible if anyone disagrees with my judgment.

Q. You admit the possibility of someone equally skilled, concluding otherwise?

MR. HANNON: Same objection. The Doctor has no way of judging what any other doctor has judged in the same circumstances at this time.

A. I think what Mr. Hannon says is true, I have no way of knowing that.

Q. If someone else had, would you regard it as negligent?

A. No more than if someone would regard me as negligent.

Q. It is in the area of judgment, in your opinion? A. Yes, sir.

Q. Where reasonable specialists in the field might differ?

A. True.

Q. That's all.

* * * * *

PLAINTIFF'S EXHIBITS 1-A and 1-B

EXCERPTS FROM MEDICAL RECORD OF GEORGIANA HARVEY,
 U.S.A.F. HOSPITAL, BOLLING AIR FORCE BASE, WASH-
 INGTON, D.C. (PLAINTIFF'S EXHIBITS A-1 THROUGH
 44 FOR IDENTIFICATION ON DEPOSITION OF
 JAMES L. EAVEY)

* * * * *

Page No.

B-3

Doctor's Progress Notes [Handwritten]

"15 Feb. 55/gyn. 28 para ? gr III (2 abr. early, and
 left tubal pregnancy with laparotomy in November 53.)

LMP about 2 or 3 January 55. About 12 days ago began to
 have lo abdominal cramps with passage of small amount of
 brown discharge. Two nights ago had marked RLQ pain &
 low back pain. Has had two negative frog tests. Last night
 passed about 1/2 cup fresh blood -- has cont'd brown dis-
 charge since. Breasts have become more firm, frequency
 of urination with burning & urgency. Also has noted some
 rectal pressure. No shoulder pain. Menses were regular
 ? 28 days until January -- LMP as recorded seemed normal.

Exam. BS ? Cervix softened, slightly cyanotic. Fundus
 anterior, not enlarged. Right adnexa tender with suggestion
 of fullness-- no discreet mass. Left adnexa (ovary) palp-
 able -- sensitive, but much less so than rt. Rectovaginal
 confirms. No cul de sac crepitus. Imp: R.O.Rt. Ectopic
 (over)"

B-2

Doctor's Progress Notes (Continued) [Handwritten]

"Rx - Admit for Exam under Anesth & Colpotomy."

[Signed] Eavey

"22 Mar. 55/gyn. Ectopic, right, removed by colpotomy
 15 Feb & D&C done. About 13-14 days later admitted with
 acute peritonitis from ruptured pelvic abscess at site of

Page No.

B-2
Cont'd.

operation -- laparotomy with drainage of abscess via previous colpotomy incision into vagina. Post-operative course good, tho for a while subphrenic (suprahepatic) abscess was in question. On ? since discharge.

"Feels well except for some generalized abdominal soreness. Some suprapubic pain during ? & some discomfort with defecation. No vaginal bleeding.

"Exam -- Incision well-healed. Minimal induration. Gentle bimanual reveals minimal pelvic fixation with induration -- left ovary sl. enlarged & tender.

"Rx - HV douches & sitz baths

TID. Ret 4 Wks." [Signed] Eavey

A-13 Nursing Notes and Treatment Record. Admitted from Clinic 13:30 * * *

* * * * *

A-15 "Authorization For Administration of Anesthesia and Performance of Operations and Other Procedures"

"(The granting of this authorization does not constitute a waiver of an individual's rights under the provisions of title 28, United States Code with reference to Federal tort claims.)"

"1. I hereby consent to the performance upon myself . . . of abdominal surgery and/or colpotomy [Handwritten part underlined]

"2. I further consent to the administration of such anesthesia as may be considered necessary or desirable in the judgment of the medical staff of the above-named medical facility.

"3. I further consent to the performance of such additional operations or procedures as are considered necessary or

Page No.

A-15
Cont'd.

desirable in the judgment of the medical staff of the above-named medical facility.

"4. I also consent to the disposal by authorities . . . of any tissues or parts which it may be necessary to remove.

"(Cross out any paragraphs above which are not appropriate).

"Signature of patient Georgiana R. Harvey

". . . WITNESS: Signature Wm. D. Johnson

* * * * *

A-44

Operation Report

Preoperative Diagnosis: Possible ectopic pregnancy.

Surgeon, Dr. Eavey; First Assistant, Dr. Johnson.

Operative Diagnosis - Tubal pregnancy, right, unruptured.

Operation Performed. Began at 1500.

"1. Partial right salpingectomy, via posterior colpotomy.

"2. D&C.

Description of Operation [Checked] "Major"

"after induction of anesthesia, perineum and vagina were routinely prepared and draped with the patient in the lithotomy position. Careful bimanual examination revealed two small masses in the right adnexal region, one thought to be ovary, the other a right tubal pregnancy. The posterior lip of the cervix was grasped with the tenaculum, and a transverse incision made in the vaginal mucosa of the posterior fornix. The cul-de-sac was entered bluntly and incision spread. The right tube was brought down into the incision, and a small unruptured tubal pregnancy found, with a small amount of blood coming from the fimbriated end of the tube. The mesosalpinx and the tube proximal to the pregnancy were

Page No.

A-44
Cont'd.

serially clamped, cut, and ligated with transfixing sutures of #0 chromic catgut. Inspection of the remaining pelvic viscera revealed both ovaries to be essentially normal. The left tube was not available. (Previous left salpingectomy). The colpotomy incision was then closed with a continuous suture of #0 chromic catgut, incorporating vaginal mucosa and peritoneum in each stitch. Anterior lip of the cervix was grasped with a tenaculum, cervical canal dilated with Hegars, and the uterine cavity thoroughly curetted with sharp curette, producing a moderate amount of tissue. Patient withstood the procedure well, and returned to the ward in good condition."

[Signed] James L. Eavey, Major, USAF(MC)

* * * * *

A-5

Tissue Examination.

Submitted by Johnson, obtained 15 Feb 55.

Specimen A is the Rt fallopian tube -- ectopic pregnancy

Specimen B is Uterine curettings. Obtained by surgical excision - D&C

Brief Clinical History "28 yr old G IV AB II ectopic II Intact rt ectopic removal via colpotomy. Curettage of uterus."

Pathological Report of Dr. Hibbs, 25 Feb. 55:

"GROSS: Specimen A: Specimen consists of 2 pieces of tissue, 1 being a friable mass of tubular tissue measuring 2-1/2x2x1-1/2 cms and the other being a hard solid mass of clotted blood 2 cms in diameter.

"Specimen B: Numerous firm pieces of grey wrinkled tissue are seen, the largest measuring .8 cms in diameter.

"MICRO: Sections of the fallopian tube show it to have much edema of the papillary folds with marked lymphocytic and

Page No.

A-5
Cont'd

fibroblastic proliferation in the wall. Frequent extravasations of red cells are seen but no definite stromal decidual reaction is noted. No chorionic villi are identifiable. The uterine endometrium is irregular, papillary and shows much infolding. It is lined by a pink staining vacuolated tall columnar epithelium which shows much stromal decidual reaction surrounding it.

* * * * *

A-18

HISTORY

Readmission Note. [Handwritten]

"28 yr old para with gr II (two ectopics) admitted with acute low abdominal pain 10 days after removal of right ectopic via colpotomy. Pain began suddenly this a.m. in RLQ and rapidly became generalized. No nausea or vomiting, had normal B.M. yesterday. Minimal post- ? discomfort past several days & minimal intermittent RLQ pain during past 3 days. Had rapid smooth recovery after colpotomy. No ulcer history."

Complete Physical Examination is Essentially Negative Except for the Following:

"B.P. 104/60. Temp. 99.4. In obvious severe pain.

Abdomen -- Board-like with marked rebound. No distention. A few bowel sounds audible. Double low midline scar well-healed. No CVA tenderness. Maximum tenderness seems to be RLQ. Rectovaginal -- marked tenderness on motion of uterus & in cul de sac but no bulging. Impossible to outline anything on bimanual."

"Imp: Surgical abdomen

- (1) Poss. twisted ovary.
- (2) " perforated viscus
- (3) " sudden early small bowel obstruction"

[Signed] Eavey

Page No.

* * * * *

A-22

Doctor's Progress Notes. [Handwritten]

"See Admission note"

"Surgical Consultation:

25 Feb 55 10 Day ?? ?

of ectopic pregnancy. Onset of severe abdominal pain since this A.M. generalized, most in right side. Had B.M. yesterday, no vomiting. T 99.4 ? Abd. flat soft with extreme muscle spasm and rebound throughout, maximum point of tenderness in the R.L.Q. Rectal, no masses.

"Impression

"Peritonitis--

(1) Early abscess

(2) Possible loop obstructing ?, etc."

[Signed] J. A. Bollinger

* * * * *

A-25

"Operation Report

Preoperative Diagnosis

Acute peritonitis, cause not determined.

Surgeon, Dr. Eavey; First Assistant, Dr. Bollinger;

Second Assistant, Dr. Gotchel.

Time Operation Began 1500, Completed 1612

Operative Diagnosis

Same Cul de sac abscess with rupture into peritoneal cavity."

Culture forwarded to laboratory.

Operation Performed: Exploratory laparotomy. Drain, pelvic abscess (via vagina)

Description of Operation [Checked "Major"]

". . . Aspiration of the pelvis revealed pus to be exuding

Page No.

A-25
Cont'd

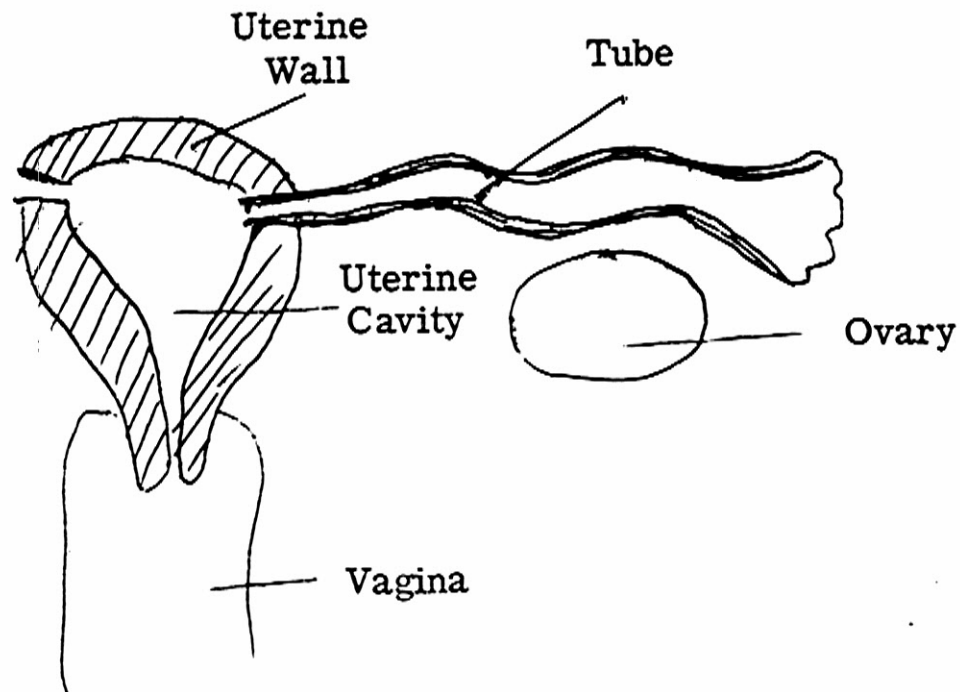
from a small abscess cavity which was bounded posteriorly into the left by the rectus sigmoid, on the right by the pelvic wall, and anteriorly by the cervix and fundus To make sure that a perforation of the rectus sigmoid had not occurred, methalyne blue solution was introduced into the rectum from below and no perforations were found. Both ovaries, and the uterus per se seemed to be normal, aside from filmy adhesions. The area of the colpotomy and previous colpotomy incision was located, and bluntly an incision made through this site into the vagina. A penrose drain was inserted into this opening. . . . Patient withstood the procedure well, and was returned to the ward in good condition."

* * * * *

B-5 23 and 27 Sept 55 Lab Reports
B-6 "16 Feb 56 [Visit]
B-7 15 Feb [Visit]
B-8 "13 June 56 [Visit]
B-9 19 Sept 56 Radiographic Report
B-10 Hematology 19 Sept. 56
B-11 Urinalysis 19 Sept 56
B-12 21 Sept 56 [Visit]
B-13 "12 Nov. 56 [Visit]
B-14 "15 Jan 57 [Visit]

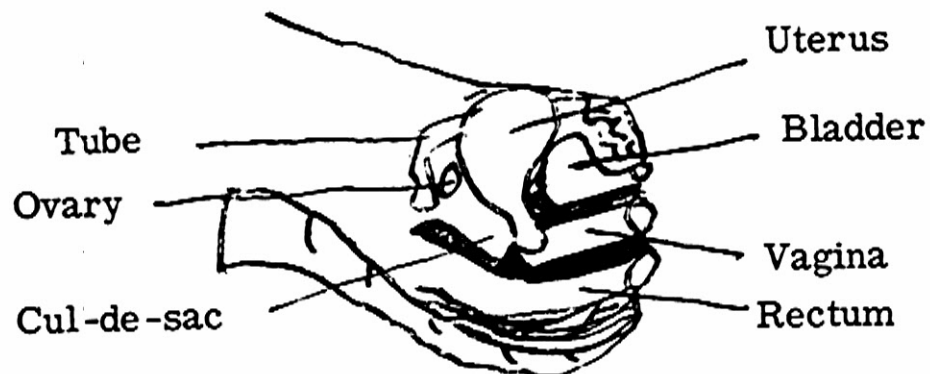
PLAINTIFF'S EXHIBIT 1-C

(Exhibit C to deposition of Dr. Eavey, p. 25-29)



PLAINTIFF'S EXHIBIT 1-D

(Exhibit D to deposition of Dr. Eavey, p. 48-49)



EXCERPTS FROM DEPOSITION OF
DR. WILLIAM D. JOHNSON

1

Wilmington, Delaware
Monday, Nov. 26, 1962

Deposition of DOCTOR WILLIAM D. JOHNSON, called for examination by counsel for the defendant. . .

* * * * *

2

DIRECT EXAMINATION

BY MR. BACON:

Q. Doctor Johnson, would you state your full name for the record, please? A. William Douglas Johnson.

Q. Where do you presently reside? A. 12 Clythe Drive, Wilmington 3, Delaware.

Q. Are you practicing medicine in the State of Delaware? A. Yes.

Q. Where are your offices located? A. 1401 Pennsylvania Avenue, Wilmington 6.

Q. Calling your attention to February of 1955, can you tell us, please, where you were located at that time? A. Bolling Air Force Base station hospital, Washington, D.C.

Q. In what capacity were you stationed there? A. I was assigned to the Obstetrics and Gynecology Service.

Q. What had been your training prior to coming to Bolling? A. I interned at Walter Reed.

3

Q. Where did you have your medical education? A. University of Pennsylvania.

Q. In February of 1955, what were your duties at the Bolling Air Force Base? A. I was ward officer on Obstetrics and Gynecology.

Q. Calling your attention particularly to the 15th of February of 1955, do you recall your duties on that day? A. I was covering the gynecology ward, among other things.

Q. Did you have occasion on that day to see Georgiana Harvey, the plaintiff in this action? A. Yes. I admitted her to the ward service.

Q. Doctor, have you had an opportunity to examine the Bolling Air Force Base records with respect to Mrs. Harvey? A. Yes.

* * * * *

4 Q. At the time you saw Mrs. Harvey where was she? A. She was on the GYN ward.

Q. Had you seen her prior to the time she came to the ward?

A. No.

5 Q. What was the nature of your contact with her on the ward on the 15th? A. I did her pre-operative history and physical examination prior to her going to the operating room.

Q. What was the nature of this pre-operative history, et cetera, you have just identified for us? A. It is in the record. It was --

Q. Would you like to look at the record? A. Yes.

* * * * *

6 Q. Approximately how long were you with Mrs. Harvey in taking this history, et cetera? A. I don't know. It would take 15 or 20 minutes to do a work up like this, or less.

Q. Do you recall approximately how long you spent with Mrs. Harvey prior to the operation? A. No more than that.

Q. Did there come a time in the course of your pre-operative contact with Mrs. Harvey that she executed a consent to operative procedures? A. Yes.

Q. Can you locate that for us in the record? A. It is Plaintiff's Exhibit A-15.

Q. Does your signature appear anywhere thereon? A. Yes, as witness.

Q. That is your signature? A. Yes.

7 Q. This consent is for what type of procedures? A. It is for abdominal surgery and/or colpotomy. It is abdominal surgery and/or colpotomy.

Q. Did Mrs. Harvey execute that in your presence? A. Yes.

Q. Did you have any conversation with her with respect to

execution of that? A. Yes.

Q. What was the nature of that conversation? A. I don't recall exactly.

Q. Did you have occasion to discuss with her the nature of the procedures that were identified on that consent? A. I don't specifically recollect discussing them with her. However, if Doctor Eavey had not, I am sure I did just because it is a matter of policy. I wouldn't permit any patient to go to surgery that they hadn't been discussed with unless I knew that Doctor Eavey had already done it.

* * * * *

8 Q. Did you have any discussion with her of the prior salpingectomy?

A. I don't recall.

Q. Did you have any discussion which would compare the prior salpingectomy in the procedures which were contemplated in February of 1955? A. I don't recall.

Q. The document which we previously identified as the consent, Plaintiff's Exhibit A-15, shows what appeared to be two procedures, Doctor, the abdominal surgery and/or the colpotomy. Upon whose authorization were those two procedures filled in there? A. Doctor Eavey's.

Q. Do you of your own knowledge know the reason for filling in the two procedures? A. It is standard procedure on tubal pregnancy if the diagnosis has not been established, that is, if it is just suspected. This could be standard procedure, if I can rephrase it.

Q. What is the purpose of its being a standard procedure, if you can explain that to us? A. What being a standard procedure?

Q. The use of the two procedures, or the authorization for two procedures. A. Colpotomy could be used for diagnosis and treatment, or just for diagnosis, and treatment achieved by abdominal surgery. I am sure that is what he had in mind when he scheduled it that way.

* * * * *

10 Q. What function, if any, did you perform during the procedures in

the operating room? A. I was the assistant.

Q. What are the nature of the assistant's duties? A. To assist the surgeon with the operation.

Q. In Mrs. Harvey's case of what did that assistance consist? A. Holding retractors; helping expose the operative site, and anything that Doctor Eavey requested. This is pretty standard on all surgical procedures.

11 Q. You did not, then, actually remove the pregnancy yourself, or make any decisions with respect to the operation? A. No. Doctor Eavey, the operator, did that.

Q. Did you have occasion to see Mrs. Harvey after the operation? A. Yes.

Q. When did you first see her after the operation? A. According to the chart I saw her at 10:00 p.m. that night on routine rounds.

Q. Did you have occasion to discuss with her then what had been done in the course of the operation? A. I don't recall. I am sure that I probably did not. This would be the province of the physician taking care of her in this case, Doctor Eavey, although if she asked me I probably would tell her. I mean I don't know I did, I don't know I didn't. But this would be primarily his responsibility.

* * * * *

Q. Do you recall whether Mrs. Harvey initiated with you any conversation? A. I don't recall.

12 Q. With respect to the procedures which you had been performing. A. Nothing unusual anyway.

Q. Did you have occasion to see her husband in the course of the post-operative days, February 16, 17, or 18? A. Yes. I met him sometime during those days.

Q. Did you have any discussion with him with respect to the procedures that had been done on February 15? A. I don't recall.

* * * * *

13

CROSS EXAMINATION

BY MR. DOWDEY:

Q. Doctor, I hope you will pardon me if I wander a little bit because I had not had the opportunity of talking to you privately before the commencement of this deposition as the Assistant United States Attorney did. May I have the record? A. Surely.

Q. Are you presently a specialist in any kind of medicine? A. Yes. Obstetrics and gynecology.

14 Q. Are you certified? A. No, I am not.

Q. Where and when did you graduate from medical school? A. The University of Pennsylvania, in June of 1953.

Q. What was your first training after that? A. I interned at the Walter Reed Army Hospital.

Q. From when to when? A. From 1953 to 1954.

Q. Where did you go from there? A. To Bolling Air Force Base, from 1954 to 1956.

Q. Do you know whether the Bolling Air Force Base Hospital was an accredited hospital at that time? A. What do you mean by "accredited"?

Q. Was it accredited by the American College of Surgeons, by the American Hospital Association? A. I don't know.

Q. You do not know? A. I do not know.

Q. What kind of gynecological staff did it have at that time you were there, 1954 to 1956? A. What do you mean by "what kind"?

Q. Tell us what it was; what was the gynecological staff there; what did it consist of? A. It consisted of Doctor Eavey, chairman of the
15 department, Doctor Manjoney. You probably know more about that than I do, actually. Doctor Vozinelek, and Doctor Peck, and myself.

Q. Who is the head of the department? A. Doctor Eavey.

Q. His qualifications at that time, I take it, in terms of experience and training in gynecology were superior to those under him. Is that

correct? A. Well, they were certainly the equivalent of everybody there. I don't know whether Doctor Eavey was certified at that time or certified just after that. Doctor Peck was certified, and I think Doctor Eavey was certified.

Q. At the time they were there? A. Peck was I know, and I think Eavey was -- either was certified then or took his examination shortly thereafter.

Q. If Doctor Eavey was head of the department, and Doctor Peck was under him, would you think Doctor Eavey would be certified then?

MISS BACON: I object to the form of asking him what he thinks.

BY MR. DOWDEY:

Q. Would that aid your recollection, to find out whether he was certified? You said you knew Doctor Peck was certified? A. I know

16 Peck was certified because he had been out in practice. I don't recall whether Eavey took his boards in 1955, 1956, or 1954. I know he took them sometime around that time. Whether he already had them or not, I don't know.

I don't see why you are laboring this. I don't understand.

Q. As a matter of fact, the record shows that Doctor Eavey was not certified while he was there. A. He took them the next year, then.

Q. I think we interrupted your history. You were at Bolling in 1954 to 1956. Then where did you go? A. I went to Presbyterian in Philadelphia from 1956 to 1958.

Q. You served your residency there? A. Residency in obstetrics and gynecology.

Q. For three years? A. Two years. I started as a second year resident. I was there second, third year resident and came to Delaware Hospital in Wilmington as a third year resident for another year, and went into practice here. I was here from 1958 to 1959.

Q. Let me see if I get this straight. You were at Presbyterian Hospital -- A. From 1956.

17 Q. -- 1956 to 1958? A. Correct.

Q. You served two years residency there. Is that it? A. Right.

Q. And then you came -- A. To the Delaware Hospital in Wilmington.

Q. To Delaware Hospital in Wilmington. A. 1958, 1959.

Q. That was your last year of residency. Is that right? A. Yes.

Q. Your senior year of residency, is that what you refer to? A. I stayed in Presbyterian as a second year resident, I was a senior resident, and came down here as a senior resident again before I went into practice here.

Q. How long have you been in practice here? A. Since July 1, 1959.

Q. Is your practice limited entirely to gynecology? A. And obstetrics.

Q. And obstetrics? A. Is that the way you are asking, is it limited to obstetrics and gynecology?

Q. Yes. A. Yes. If you are asking is it limited to gynecology, it
18 is limited to obstetrics and gynecology.

Q. How long has it been so limited? A. Since I went in practice in 1959.

* * * * *

Q. Was there a consultation in this case? A. Not that I know of.

Q. Do you know that a consultation is required in this kind of operation? A. You are stating that as a positive statement. I would think not.

Q. You would think not? A. Why do you say that it is? I don't understand.

Q. Well, is it --

MISS BACON: I believe you had his answer, Mr. Dowdey. He says
19 he does not believe it is required in this kind of case.

THE WITNESS: I don't think it is required in this sort of thing with anybody like Doctor Eavey.

BY MR. DOWDEY:

Q. It wouldn't be? A. I wouldn't think.

Q. Wasn't the consequence of this a sterilization? A. Yes.

Q. You have been studying for your boards, haven't you? A. Yes.

Q. And isn't that one of the operations that requires a consultation?

A. Yes. But this was an emergency procedure.

Q. It was an emergency? A. As far as I know.

Q. Is that right? Show us where it shows in that record it is an emergency. A. Where can you show me in the record that it doesn't -- that it wasn't? We scheduled this patient in the afternoon, or she was scheduled from the out-patient clinic and sent to surgery right after the normal working day. I think that would qualify it as an emergency.

20 Q. Let me put -- A. It depends upon what you are calling an emergency. It would certainly seem to me it was done late that afternoon.

Q. Let me put it this way: You merely assisted in this, and whether it was an emergency or not you would defer to Doctor Eavey's statement as to that matter, wouldn't you? A. I don't know what he stated.

Q. I mean it would be his judgment as to whether it was an emergency or not, not yours. A. You asked me. You asked me specifically.

Q. You think it was an emergency?

* * * * *

21 MR. DOWDEY: Well, now, I think my last question, whether it was my last question or not, to extricate us from this dilemma, I would say that your capacity at the operation was that of assisting Doctor Eavey. Is that right?

THE WITNESS: That is right.

BY MR. DOWDEY:

Q. And so it would be his judgment that would control what was done rather than yours about consultation, or about emergency, or about anything else. Is that right? A. That is right.

Q. So your opinion on the matter would be surplusage? A. It would be surplus, but you still asked me.

22 Q. I ask you again: Isn't a consultation required even of a specialist for therapeutic termination of a pre-term intrauterine pregnancy?

A. Yes. But this was not an intrauterine pregnancy.

Q. What was it? A. It was a tubal pregnancy.

Q. Isn't consultation required there? A. I don't think so. I don't think consultation is required for excision of the tubal pregnancy.

Q. Even though one tube had been removed previously and the effect of such operation is to produce sterility? A. The effect was not to produce sterility, but was to take out the pathology and remove the threat of rupture.

Q. That did not effect the sterility? A. It was not done to effect sterility.

Q. Did it effect sterility? A. It was not done to effect --

Q. I just asked you did it? A. Secondarily, yes, but that was not what it was done for.

Q. I didn't ask you that. A. You started out asking me that. I think you are right on your intrauterine pregnancy, though.

Q. There is no question that in view of the prior history that you took, which showed she had an ectopic pregnancy on the other side, that
23 the removal, partial or otherwise of this remaining tube would effect a sterilization, is there? A. Yes. But the procedure was not done to effect a sterilization; it was to remove the tubal pregnancy.

Q. Did you have a tissue committee at the hospital, Bolling? A. Not as I recall. They were so short-handed that they didn't have a lot of things. They had one pathologist. I don't recall the presence of a tissue committee.

Q. At that time had you ever seen an operation for removal of an unruptured tubal pregnancy at the time of this particular operation in February of 1955? A. At that time I don't think I had ever seen but one or two operations for tubal pregnancy, period.

Q. Of any kind? A. Of any kind.

Q. Much less of an unruptured kind. A. I think that was the first unruptured one I ever saw, as I recall.

Q. I will digress a moment. Do you have any independent recollection of the kind of experience Mrs. Harvey had had in the previous ectopic pregnancy? A. No, none. I just took the history and recorded that she had had a salpingectomy.

24 Q. Apart from that. A. I had no independent recollection.

* * * * *

25 Q. To get back to the consultations, isn't a consultation required in all operations which may interrupt a known, suspected, or possible pregnancy?

26 MISS BACON: Objection. You have had the answer to this type of question already, Mr. Dowdey.

THE WITNESS: Do I answer anyway?

No, not under emergency circumstances. These are often done without consultation where tubal or an ectopic pregnancy was suspected.

BY MR. DOWDEY:

Q. Apart from the existence of an emergency, consultation would be required. A. Apart from an ectopic pregnancy I think it would be required, but I have never heard this come up before, but I wouldn't think a consultation --

Q. Would you like to look at this? A. Not especially.

Q. All right. A. Does that say a consultation is required for an ectopic pregnancy?

Q. I didn't ask you --

MISS BACON: May the record show to what you are referring?

MR. DOWDEY: The record will show I am referring to the Standard for Hospital Accreditation of the Joint Commission on Accreditation of Hospitals, paragraph B-3, entitled, "Consultations."

* * * * *

27 THE WITNESS: I do not think the Joint Committee for Accreditation of Hospitals can make requirements; I think all they can do is recommend.

I am sure this may well be their recommendation, but I do not think they can require it. Is this not true?

Is this a recommendation of them rather than a requirement?

28

BY MR. DOWDEY:

Q. You are familiar, I take it, with what is required to get a hospital certified -- Pardon me. I mean accredited. And they lay down certain standards, do they not, as condition to being accredited?

MISS BACON: Objection. There has been no statement that he is qualified to determine what constitutes an accreditation.

MR. DOWDEY: I may be helping him out here.

BY MR. DOWDEY:

Q. Are you familiar with that? A. I think they can still make only recommendations.

Q. Then they can withhold their accreditation -- A. That is right.

Q. -- if those standards are not met. A. That is right.

Q. Right. Now, I ask you again whether or not a consultation is required for any operation which may interrupt a known, suspected, or possible pregnancy, and, absent, of course, emergency conditions which would prevent -- A. I have to say I don't know because of this business of "required." I don't think the Joint Committee can set requirements. I think this is in the nature of --

Q. Apart -- A. -- of a hospital.

29 Q. Would good practice require it? A. In the case of a tubal pregnancy? No.

Q. No. I didn't say that. A. You asked me if it was good practice; is it required. No, it is not. It is good practice to take care of an ectopic without consultation.

Q. Why? A. Because they are a threat to a patient's life.

Q. Right. They are emergencies? A. Right.

Q. If they are not emergencies then consultation would be required?

A. I would assume that an ectopic is an emergency.

Q. Now, just depart from that for a moment and assume it is not, then a consultation -- A. I can't assume an ectopic not being an emergency.

Q. You can't? Well, some others have. A. Okay. Fine.

Q. Just assume it is not an emergency, then consultation would be required, would it not?

MISS BACON: Mr. Dowdey, is this --

THE WITNESS: I don't think so.

30

BY MR. DOWDEY:

Q. Why? A. Because I don't think this is the practice.

Q. You don't think it is an emergency, but if it is not an emergency the only reason -- A. I do think an ectopic is an emergency.

* * * * *

Q. If you will assume it is not an emergency -- just assume that, that it is not an emergency -- then consultation would be indicated, wouldn't it?

* * * * *

31 THE WITNESS: I am not qualified to answer it as you asked it.

Q. Simply because you can't conceive of an ectopic being other than an emergency condition. Is that right?

* * * * *

THE WITNESS: I can conceive of some ectopics not being an emergency, but I think this one was an emergency.

BY MR. DOWDEY:

Q. You think this one was an emergency, but you can conceive of them as not being emergencies. Is that right? A. Ectopic pregnancy?

Q. Yes. A. I can conceive of an ectopic pregnancy not being an emergency, but not this one.

Q. But not this one. If Doctor Eavey thought otherwise you would not argue with him, would you? A. I might argue with him, yes.

Q. Did you argue with him? A. Are you talking about now or then?

Q. I am just trying to get that straight with you. Did you argue with him?

32

* * * * *

THE WITNESS: It wasn't my place to argue with him.

BY MR. DOWDEY:

Q. You didn't argue with him then? A. No. I didn't argue with him then. It wasn't my function. This was not my function.

Q. Admitting, therefore, the possibility of an ectopic not being emergencies, if it is not an emergency would a consultation be required?

MISS BACON: Under what -- Mr. Dowdey, I have an objection to that question.

Would a consultation be required by whom? Do you have any further qualifications?

MR. DOWDEY: Just a moment. Let the doctor answer the question, if he can.

* * * * *

33 Will you read the question again, and see if the doctor can answer it.

(The question was read by the reporter as follows:)

"Question: Admitting, therefore, the possibility of an ectopic not being emergencies, if it is not an emergency would a consultation be required?"

MISS BACON: I have an objection, and direct the witness not to answer the question if the question is in that form.

* * * * *

PLAINTIFF'S EXHIBIT 2

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS STANDARDS FOR HOSPITAL ACCREDITATION

The structure, organization, and facilities of a hospital determine its acceptability for accreditation by the Joint Commission on Accreditation of Hospitals. The degree to which these three factors has been

developed in the United States and Canada is an index to the advance in medical care. Extremely high standards have been reached in many institutions, but certain requirements are essential for any hospital to be accredited.

An abbreviated exposition of the standards established by the American College of Surgeons and accepted by the Joint Commission on Accreditation of Hospitals when the Commission assumed the responsibility for accreditation from the American College of Surgeons on December 6, 1952 are presented. The few changes made by the Board of Commissioners of the Joint Commission are herein incorporated.

The standards are divided into required and contingent, arranged on a basis of function. The required standards are essential for the accreditation of all hospitals. The contingent standards are dependent upon the type, size, degree of departmentalization, and financial resources of a particular hospital.

REQUIRED

The following standards are held to be absolute prerequisites to accreditation by the Joint Commission on Accreditation of Hospitals. They are arranged in three sections, according to the major functional divisions of a hospital.

* * * *

[II B] 3. Consultations

Except in emergency, consultation with a member of the Consulting or of the Active medical staff shall be required in all major cases in which the patient is not a good risk, or in which the diagnosis is obscure, and in all first caesarean sections, sterilizations, curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation, the con-

sultant may, and in the case of free patients shall, give his services without charge. This Standard is applicable to all members of the medical staff.

* * * * *

PLAINTIFF'S EXHIBIT 3

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS STANDARDS FOR HOSPITAL ACCREDITATION

FOREWORD

* * * * *

These Standards are considered necessary to insure the quality of medical care in hospitals which the Joint Commission can faithfully recommend to the public. They are not arbitrary or rigid in spirit yet they require general conformity to achieve accreditation by the Commission.

* * * * *

The Standards are divided into basic principles and methods of procedure. Adherence to the basic principles is essential for the accreditation of all hospitals. The procedures are recommended as guides, dependent upon the type, size, degree of departmentalization and resources of a particular hospital.

* * * * *

January 28, 1956

II. MEDICAL STAFF

A. Responsibilities

The governing body of the hospital must obviously delegate the responsibility of medical functions to medical staff, including recommendations as to the professional qualifications of all who practice in hospital. The medical staff is responsible for the quality of medical care rendered to patients in the hospital. Maintaining

high standards of medical care will depend upon the character of the staff and effectiveness of its organization to carry out the following duties:

- * * * * *
6. Holding of necessary consultations. Except in emergency, consultation with another qualified physician shall be required in all first Caesarean sections and in all curettages or other procedures in which a known or suspected pregnancy may be interrupted. The same requirement shall apply in operations performed for the sole purpose of sterilization on both male and female patients. Included in consultations required under this Standard are all those which are required under the rules of the hospital staff. In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Obviously, judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital staff through its chiefs of service and Executive Committee to see that members of the staff do not fail in the matter of calling consultants as needed. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made part of the record. When operative procedures are involved the consultation note, except in emergency, shall be recorded prior to operation.

* * * * *

PLAINTIFF'S EXHIBIT 4

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

This represents the first list of accredited hospitals published by the Joint Commission on Accreditation of Hospitals.

The hospitals named are those which are accredited by the Joint Commission on Accreditation of Hospitals as of December 31, 1953.

* * * * *

The omission of a hospital from this list does not necessarily mean that the hospital fails to meet the Standards of the Joint Commission. It has not been possible in 1953 to visit all hospitals and act on all requests for accreditation.

* * * * *

DISTRICT OF COLUMBIA

WASHINGTON

Central Dispensary and Emergency Hospital
 Children's Hospital
 Columbia Hospital for Women
 Doctors Hospital
 Eastern Dispensary and Casualty Hospital
 Episcopal Eye, Ear and Throat Hospital
 Gallinger Municipal Hospital
 Fairfield Memorial Hospital
 Georgetown University Hospital
 George Washington University Hospital
 National Homeopathic Hospital
 Providence Hospital
 Sibley Memorial Hospital

MARYLAND

BETHESDA

Suburban Hospital

CHEVERLY

Prince George's General Hospital

VIRGINIA

ALEXANDRIA

Alexandria Hospital

ARLINGTON

Arlington Hospital

U.S. GOVERNMENT AGENCIES

DEPARTMENT OF DEFENSE

U.S. ARMY

Fort Belvoir, Virginia

Walter Reed Army Hospital

Washington, District of Columbia

U.S. Soldiers' Home Hospital

Washington, District of Columbia

U.S. NAVY

Bethesda, Maryland

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

WASHINGTON, D.C.

Freedmen's Hospital

St. Elizabeth Hospital

VETERANS ADMINISTRATION

DISTRICT OF COLUMBIA

Washington

PLAINTIFF'S EXHIBIT 5

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

This represents the third list of accredited hospitals published by the Joint Commission on Accreditation of Hospitals.

The hospitals named are those which are accredited by the Joint Commission on Accreditation of Hospitals as of December 31, 1955.

* * * * *

The omission of a hospital from this list does not necessarily mean that the hospital fails to meet the Standards of the Joint Commission. It has not been possible in the two years the Commission has been in existence to visit all hospitals and act on all requests for accreditation.

* * * * *

DISTRICT OF COLUMBIA

WASHINGTON

Central Dispensary and Emergency Hospital
Children's Hospital of the District of Columbia
Columbia Hospital for Women
District of Columbia General Hospital
Doctors Hospital
Eastern Dispensary and Casualty Hospital
Episcopal Eye, Ear and Throat Hospital
Garfield Memorial Hospital
Georgetown University Hospital
George Washington University Hospital
Providence Hospital
Sibley Memorial Hospital
U.S. Soldiers' Home Hospital

MARYLAND

BETHESDA

Suburban Hospital

CHEVERLY

Prince George's General Hospital

ROCKVILLE

Chestnut Lodge Sanitarium

TAKOMA PARK

Washington Sanitarium and Hospital

VIRGINIA

ALEXANDRIA

Alexandria Hospital

ARLINGTON

Anderson Orthopedic Hospital
Arlington Hospital

U.S. GOVERNMENT AGENCIES

DEPARTMENT OF DEFENSE

U.S. ARMY

Fort Belvoir, Virginia
Walter Reed Army Hospital
Washington, District of Columbia

U.S. NAVY

Bethesda, Maryland

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

WASHINGTON, D.C.

Freedmen's Hospital
St. Elizabeth Hospital

PUBLIC HEALTH SERVICE

Bethesda, Maryland

VETERANS ADMINISTRATION

DISTRICT OF COLUMBIA

Washington

PLAINTIFF'S EXHIBIT 6

MEDICAL RECORD - MT. SINAI HOSPITAL, of GEORGIANA
EUMONT, Age 26, of Buffalo, New York, living at Cleveland Hotel
in Miami, * * *

Admitted to the hospital November 4, 1953 at 9 p.m. at request of
her physician, Dr. Harold P. Auslander (p. 1). Received a blood trans-
fusion at 11 p.m. (p. 18).

Her History, taken sometime November 5, showed her chief com-
plaint was lower abdominal pain -- three weeks. Past history showed
that her "last menstrual period was September 15, 1953, lasting two
days. She began to experience lower abdominal cramps, about October
15, 1953. They became more intense and spotting became apparent
about October 18, 1953. This gradually increased to a stain and then a
moderate flow. For the past two weeks the pain was centered in both
lower quadrants and in the rectum. Any effort at movement produced
excruciating pain and she was unable to sit comfortably. She then be-
gan to experience dizziness, ? excessive thirst and perspiration.
Examination in the office November 5 [an apparent misdate] in a.m.
revealed mass in the cul-de-sac . . . patient was advised to go to the
hospital.

Past history included an appendectomy not ruptured. Nothing else of significance, and general health had been excellent. (p. 2)

November 5, at 2:10 p.m. she went to surgery and returned at 3:45 p.m. (p. 19).

* * * * *

The operative record shows laparotomy in great detail. Indicates ectopic pregnancy was apparent in the left tube; that the mesosalpinx was clamped off and the tube removed.

Dr. Auslander was assisted by Dr. Rose and another physician (p. 11, 13). Dr. Rose saw the patient before the operation according to the nurse's notes (p. 19). The consultation report of Dr. Rose is dated November 7, 1953. It recites the history in detail. It recites that the diagnosis of a ruptured ectopic pregnancy was confirmed by surgery.

* * * * *

The nurse's notes November 9, 1953 show the wound was still bleeding on that date. However, complaints subsided on the 10th, and she was discharged on the 11th (p. 24-25). Previous reports (p. 18 et seq.) indicate considerable pain.

* * * * *

PLAINTIFF'S EXHIBIT 7

Letter of Dr. J.C. Wilson dated September 28, 1962
addressed to United States Attorney:

"I find that we have lost the records on Mrs. Georgiana Harvey instant to physical moving of our clinic. However, I remember her quite well since both she and Mr. Harvey were quite colorful individuals. I treated her for possibly 14 months at various times in the years '55 and '56, as I recall, for many functional complaints and problems, most of which were related to the pelvis.

"She gave a history of having been operated on at Bolling Air Force Base a few years previous for a tubal pregnancy and stated that the Air Force doctor had caused her to be sterile. Actually, I do not feel that this was true since she had one spontaneous abortion while under my care. It was my impression that her complaints were chiefly functionally related although there was evidence of pelvic inflammatory disease."

PLAINTIFF'S EXHIBIT 8

Records of Frederick R. Braden, M.D.
Forwarded to U.S. Attorney, November 26, 1962

Dear Dr. Braden:

About one year ago Mrs. Georgiana Harvey was examined in my office at which time she was thought to be 6 to 8 weeks pregnant. A missed abortion occurred, which was spontaneously extruded (according to her history)

She has requested that I write you this information.

Sincerely,

/s/ Joseph C. Wilson, M.D.
White-Wilson Clinic
Ft. Walton Beach, Florida

Operative Record

2/12/58 By Dr. Braden Assisted by Dr. Patton for hysterectomy and right salpingo-oophorectomy, began 9:20 A.M. Closed 10:30 A.M.

Pre-Operative Diagnosis

Chronic oophoritis, previous bilateral salpingectomy, menorrhagia, functional uterine bleeding, chronic cervicitis. Post-operative diagnosis same.

Procedure: Total abdominal hysterectomy, right oophorectomy, removal of stump of right tube.

Technique: Under general anesthesia, patient in supine position, prepped and draped in a routine manner. Subumbilical midline incision made with excision of old scar. Upon entry of the abdominal cavity, there were numerous adhesions between the anterior abdominal wall at site of previous incision and pelvis to large and small bowel. Upon examination of the pelvic organs, the right tube and ovary showed signs of chronic inflammatory disease. The distal end of the right tube had been removed at previous surgery and no patency was demonstrated of the remaining portion of the right tube. The left tube had been removed completely with loops of adhesions surrounding the left ovary, which was plastered to the posterior aspect of the left broad ligament, which were freed by blunt and sharp dissection. A total hysterectomy, right salpingectomy was then performed by clamp, cut and tie method. Reperitonealization and suspension of the vaginal vault accomplished by bilateral purse-string sutures to include the uterosacral, cardinal, round, and infundibopelvic ligaments. Exploration of the abdomen revealed no pathology other than numerous adhesions. Abdominal wound closed.

In anatomic layers, using chromic zero on the peritoneum, chromic #1 on the fascia, plain 000 catgut on the subcutaneous tissues and interrupted cotton on the skin. Estimated blood loss approximately 300 cc. 500 cc. replacement. Patient withstood the procedure well and sent to recovery room in good condition.

Pathological Report

2/12/58 Source of specimen: scar tissue; uterus, cervix, part of right tube, right ovary. Clinical diagnosis: functional bleeding.

Gross description: Received informalin of 4 specimens, the largest a previously-opened uterus with cervix and one adnexa attached (right adnexa). The uterus measures approximately 8x5.5x4.5 cm. The serosal surface is roughened by adhesions. The exocervix is smooth and grayish white. The endometrium measures 4 mm. and is reddish yellow. The fallopian tube is club-shaped and the distal end is sealed by adhesions. There are dense fibrous adhesions between the tube and ovary. The tube and ovary form an adnexal mass measuring 3 cm. The second largest specimen is a strip of scarred skin measuring 8x2 cm. and the two remaining specimens measure 1.5 cm. in aggregate and are composed of soft, reddish yellow tissue. A few small follicular cysts are present in the ovary. 4-2

Microscopic description: Sections show endometrium in the early progestational phase. There is an infiltration of chronic inflammatory cells in the cervical stroma. The villi of the fallopian tube are thickened by chronic inflammatory changes. Small follicular cysts are present in the ovary.

Pathological diagnosis: Chronic pelvic inflammatory disease. Chronic salpingo oophoritis, right adnexa. Endometrium early progestational phase. Chronic cervicitis. Small follicular cysts of the right ovary.

PLAINTIFF'S EXHIBIT 9

Letter of Dr. James A. Vaughn, Jr., of Coral Gables, Florida
dated November 2, 1962 to United States Attorney:

Mrs. Georgiana Harvey was seen by me, for the first time, on August 23, 1958. She was brought into the office by her husband, retired Lt. Col. Julian Harvey. The patient was nervous, and having hot flashes and apparent menopausal symptoms. She stated she had had a hysterectomy in April and also received psychiatric treatment by Dr. Griving, in Cuba. The patient was given an IM injection of hormones, an IM injection of Luminal, and placed on Equinal.

Her past history was not too clear. However, this much was obtained: In 1953 she had an ectopic pregnancy. She also had surgery, at the Bowen Airforce Base Hospital in 1955, for vaginal spotting. The patient states she had a hysterectomy in 1958 for excessive bleeding.

She was seen again on September 20, 1958. At that time, her temperature was normal, blood pressure was 100/80 and pulse-80. She was again given an IM injection of hormones and Tuinal capsules for sleep. The patient continued to complain of nervousness.

Mrs. Harvey was seen on October 6, 1958 with similar problems. She was given both estrogen and Oritone, in a mixture, IM. She was seen again on October 28 and stated that she thought the hormones were helping her. She was given one more IM injection and then placed on oral hormones.

On December 15, 1958, she was seen by Dr. Ramon Maseda, my associate, who treated her for an upper respiratory infection and sinusitis.

I have a notation on her chart, dated January 5, 1959, that she is back with the colonel and her nerves are better. She was given more hormones and vitamins.

On January 28, 1959, the patient was complaining of pain around the eyes and blurring of vision. She states she had had this type of headache in recent months. Cafregot did give her some relief. Hormones and Empirin #3 were given.

I had a telephone conversation with her on March 20, 1959, concerning a possible cystitis, and prescribed sulfa, at that time.

The patient was seen again in June, 1959 because of excessive weight gain. She had gained 15 pounds recently. She stated she had half of one ovary left. She was smoking excessively and drinking coffee. Pulse was 100, blood pressure-120/80. A BMR was done which showed a minus 7. PBI was 3.6. The patient was placed on dessicated thyroid, 1/2gr. t.i.d. and continued on all estrogens. The patient was improved.

Patient was seen on August 1, 1959 complaining of being excessively tired. She stated she thought she was becoming a neurotic. She was emotionally upset and afraid that she would have a nervous breakdown. She states she is unable to concentrate and has mental and emotional blocks.

The next contact I had with this patient was on September 14, 1962, when she telephoned me from Washington and told me to let the U.S. Dept. of Justice have her medical records.

PLAINTIFF'S EXHIBIT 10

Principles of Medical Ethics
of the American Medical Association
1949

* * * * *

Article III. Duties of Physicians in Consultations

Consultations Should Be Encouraged

Section 1. - In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

Consultation For Patient's Benefit

Sec. 2. - In every consultation, the benefit of the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

* * * * *

Conflict of Opinion

Sec. 7. - Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

* * * * *

PLAINTIFF'S EXHIBIT 11
EXPLANATORY SUPPLEMENT
to the
STANDARDS FOR HOSPITAL ACCREDITATION
of the Joint Commission on Accreditation of Hospitals
December 1960

The purpose of this document is to explain the meaning of some of the Standards and the underlying reasons for them. * * *

* * * * *

6. In considering the Standard of Consultations, one should have clearly in mind what the purpose of this standard is. In the matter of consultations in which the interruption of pregnancy is involved, we are dealing not only with the protection of the patient and the fetus, but also of the doctor and the hospital. No matter how clearly an operative procedure of this nature may be indicated, it is an accepted principle that two or more physicians should agree before it is carried out. We are dealing here with not only professional but also moral and legal considerations. In considering first Caesarean sections and sterilizations, the situation is similar. The consultant in both instances need not be senior to the attending physician.

In the case of other consultations, those in which serious illness, poor medical and surgical risk or obscure diagnosis is involved, it seems almost impossible to specify the conditions under which such consultations shall be required. In general, it is the conscience of the attending physician which will determine whether or not a consultation is needed. A standard which requires consultations in such instances would be for the purpose of controlling those physicians and surgeons who are less than normally conscientious and are willing to subject their patients to risk in order to maintain their own independence of action. It does not appear to be practicable to promulgate such a standard, and it would

seem more fitting to leave this to the individual hospital staff. At the same time, a lack of records of consultations will constitute reasonable grounds for criticizing a hospital. All hospitals that deal with acute medical and surgical illness will, of necessity, have many instances in which consultations are indicated.

The question has been raised as to the definition of a consultant. A consultant is a second physician called by the attending doctor to examine and discuss his patient. In the sense in which we use the term, it does not necessarily imply seniority. If the Chief of a service calls one of his junior men who may have been working in a special field - say for instance, pulmonary physiology or hematology - the younger man in seeing the patient is the consultant and should write the consultation note. The members of the consulting staff are on that staff because they have qualifications that make them valuable as consultants; but, in a given instance, any physician who sees a patient with a colleague is the consultant on that case, no matter what his standing on the staff may be. Of course, it is common for physicians to aid each other at times, informally, but in all instances in which the second physician makes a careful study of the problem presented by the patient, the consultation should be formalized by a note on the record. Although as stated above a consultant is, by definition, a second physician called to examine a patient, to satisfy the requirements of the Commission as stated in the Standard, the consultant must be qualified by training and/or experience to give a competent opinion in the special phase of the patient's illness about which he has been called to examine the patient. The determination of the consultant's competence should be made by the hospital staff. As stated in the Standard, a consultation is not complete or satisfactory unless it includes an examination of the patient and the patient's record and a written opinion signed by the consultant and attached to the record.

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PLAINTIFF'S EXHIBIT 12

Principles of Medical Ethics

Opinions and Reports of the Judicial Council

June 7, 1958 Edition of Journal of American Medical Association
(Special Edition)

PREAMBLE

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."

Section 6

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Section 8

"A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby."

"The Judicial Council is of the opinion that Section 8 of the Principles of Medical Ethics, 1957, embraces the spirit and intent of several sections of the 1955 Edition . . . including . . . Chap. V, Section 1 (Consultations should be encouraged) . . . Section 2 (Consultation for Patient's Benefit) . . . Section 7 (Conflict of Opinion).

TRANSCRIPT OF PROCEEDINGS

Washington, D.C.

April 14, 1964

The above-captioned cause came on for trial before the
HONORABLE ALEXANDER HOLTZOFF, United States District Judge,
commencing at 11:05 A.M.

APPEARANCES:

For the Plaintiffs:

LANDON G. DOWDEY, ESQ.

For the Defendant:

SYLVIA BACON, ESQ.,

JOSEPH HANNON, ESQ.

Assistant U.S. Attorneys

3 OPENING STATEMENT BY COUNSEL IN BEHALF
 OF THE PLAINTIFF

MR. DOWDEY: If the Court please, this case involves an operation
4 on a young woman which rendered her sexually sterile, that is, de-
prived her of the right, or more accurately the chance of having off-
spring.

THE COURT: Was she a married woman?

MR. DOWDEY: Yes, Your Honor.

THE COURT: Did she have children previously?

MR. DOWDEY: No, Your Honor.

In the course of an operation undertaken as a diagnostic
procedure the government physician claims to have found a diseased
condition of this young woman's last remaining Fallopian tube, namely
an early ectopic pregnancy. By his own admission he had a choice of
either amputating or repairing this tube, which in the circumstances
was a choice between preserving or destroying the patient's childbear-
ing function. He chose—

THE COURT: Before you come to that, who is the physician, what

is his connection with the government, and what is the plaintiff's connection with the government?

MR. DOWDEY: The plaintiff was a military dependent and she was treated at Bolling Air Force Base Hospital here in the District of Columbia.

THE COURT: I see.

MR. DOWDEY: Now, the operating surgeon, a Dr. Eavey, a member of the medical staff at that hospital, chose amputation. He chose to
5 amputate this Fallopian tube. Now we say he had no right to make such a choice, that is what not—

THE COURT: What was the other choice?

MR. DOWDEY: The other choice was repairing the tube. He had a choice, by his own admission, either of amputating or repairing this tube, which in the circumstances was a choice between sterilization and preserving the childbearing function. Now we say he had no right to choose amputation, that it was not a matter committed to his medical judgment. As long as there was any possibility of successful treatment, the physician was legally and morally bound to treat rather than destroy the tube. Now, he consulted no one, although the published standards of all accredited hospitals in this community, and throughout the United States, for that matter, require consultation with another physician before performing such an operation. The operating surgeon admitted that a man of equal skill in the same circumstances might, with equal justification, have sought to preserve the patient's childbearing function.

THE COURT: When you say he admitted, where is the admission?

MR. DOWDEY: In his deposition which was taken in Florida.

THE COURT: I see.

MR. DOWDEY: Now, he was asked on that deposition, which was
6 taken in 1960, if the Court please, "It is in the area of judgment, in your opinion?" and he answered, "Yes, sir." "Where reasonable specialists in the field might differ?" And he answered, "True."

Now, furthermore, although he had such a choice to amputate or repair, he never informed his patient of this choice. He allowed her to believe—

THE COURT: I take it the patient was under anesthesia at the time, wasn't she?

MR. DOWDEY: At the time of the operation, yes, Your Honor.

THE COURT: So he could not have informed her.

MR. DOWDEY: He should have informed her beforehand, because this was a choice. The ordinary choice in this type of surgery—

THE COURT: Perhaps I misunderstood you. I understood you to mean that he was operating for something else and he discovered this diseased tube. Was that it?

MR. DOWDEY: He operated for a suspected ectopic pregnancy.

THE COURT: I see. What kind of a pregnancy?

MR. DOWDEY: A suspected—in other words, he suspected an ectopic pregnancy.

THE COURT: What is an ectopic pregnancy?

7

MR. DOWDEY: It means any growth, fetal growth outside of the uterus.

THE COURT: I see.

MR. DOWDEY: I was trying at the outset, though, to delineate the questions involved in this case.

THE COURT: Yes.

MR. DOWDEY: Now I think this case involves two very serious and fundamental questions. First, given the choice between equivalent medical techniques, was he not obligated to choose that technique which would preserve function, that would save her childbearing function? We
8 say he was so obligated. To what extent is the selection of a technique which will destroy this childbearing function a matter committed to his personal judgment? Now, all will admit that if such an operation, an operation necessarily involving sterilization may be resorted to save the woman's life, if there is no other choice, but short of that necessity, surgical necessity, can it be removed for any other purpose for the greater comfort or convenience of the patient, or the elimination of future medical risk: The law is clear, I believe, that causes short of necessity do not provide justification. A patient has the right to assume that important parts of his body will not be mutilated, that is, removed

or functionally destroyed unless there is no alternative, however difficult, that will preserve the limb or organ involved, and an additional restraint is operative where the mutilation would produce sterility. Traditionally, sterilization and abortion have been treated as moral and legal equivalents.

THE COURT: I suggest that you present your arguments at a later stage, at the conclusion of the case.

MR. DOWDEY: Very well.

THE COURT: I do not think you need argue the law or the morals in your opening statement.

MR. DOWDEY: Very well. I did want delineate these questions.

9 THE COURT: Yes, I want you to do that.

MR. DOWDEY: Because these are the ones that are involved and there are many other things that come up that are not involved, so as long as we keep our attention on these matters, the trial will be more helpful.

Now the second question disregards the question of medical necessity altogether. The second question is in the nature of a procedural question, that is, who decides on sterilization, vel non? Is it solely up to the operating surgeon? To what extent must he consult his patient? This involves the obligation to fully inform the patient.

THE COURT: May I interrupt you. Do I understand that you have taken some depositions in this case?

MR. DOWDEY: Extensively, Your Honor. I think we have a large collection of them.

Now, the second aspect of this, is it solely up to the operating surgeon—is it the operating surgeon alone who decides or must he consult with another specialist? We say he must consult under existing standards, and that the only dispensing cause is an emergency. Now, I submit that these questions do not depend on medical criteria or the subtleties of gynecological surgery. The facts are essentially undisputed. All the necessary expertise in this case comes from the impeccable source, namely, the operating surgeon himself. Indeed it is
10 his own testimony that poses the questions just outlined.

Now, if I may briefly outline the course of events in this case, in February of 1955 the plaintiff was then aged 28 and she went to Bolling Air Force Base Hospital where she was entitled to medical care as the wife of an Air Force officer. She had never been to a military hospital before. She first went to the clinic some time around noon, and she saw Dr. Eavey there. He was Chief of the Gynecological Service at Bolling. After examining her, he made a diagnosis of a suspected ectopic pregnancy and ordered her admitted for examination under anesthesia, a further diagnostic technique.

Now, as I have said, an ectopic pregnancy is one which occurs outside the uterus. The most common type of ectopic pregnancy is one which occurs in the Fallopian tube, and is known as a tubal pregnancy. Frequently, in speaking of ectopic pregnancy, it refers to the ordinary type, which is a tubal pregnancy.

THE COURT: Does it occur inside the Fallopian tube or immediately outside of it?

MR. DOWDEY: Inside the Fallopian tube, or an ectopic pregnancy could occur on the ovary itself, but a tubal pregnancy is inside the tube. Now, we have a drawing here, Exhibit C, from the deposition of Dr. Eavey, in which I will try to illustrate the anatomy of this area.

11 THE COURT: I suggest you stand over on this side. I think this is better.

MR. DOWDEY: Very well. This is Exhibit D to the deposition of Dr. Eavey, and this is an enlargement of the drawing made by Dr. Eavey. Now, it shows here the vagina and the uterine wall, and coming through the uterine wall is the Fallopian tube, and here is the ovary. We do not show a Fallopian tube on this side, but normally there would be. Now, the different parts of the tube are important. This part where it enters the uterus is called the isthmus. This other end, the farthestmost end, is called the fimbriated end.

THE COURT: It is called what?

MR. DOWDEY: The fimbriated end, and the outer third of the tube, that is, the part closest to the fimbriated end is known as the ambullary end. Now, in the ordinary course of events an egg, or an ovum, is fertilized in the Fallopian tube, and after being fertilized, usually in the

outer third or ambullary end, it descends through the tube and attaches itself to the uterine wall where it is nourished and eventually and hopefully is delivered. Now, what happens in a tubal pregnancy, or an ectopic pregnancy, is that the fertilized egg or ovum, instead of descending and moving through the tube, attaches itself to the tube and does not move. Now, this is a very serious medical condition because
12 the hazard is rupture and hemorrhage, or abortion and hemorrhage.

THE COURT: I would like to inquire of you—perhaps I am anticipating something—did the doctor find an ectopic pregnancy existed or not?

MR. DOWDEY: This isn't so easily determined, and the indications are that there was an ectopic pregnancy. However, the pathological report failed to show placental tissue, which is the only definitive proof.

THE COURT: I see.

MR. DOWDEY: As I said, the chief danger in an ectopic pregnancy is hemorrhage, and therefore ectopic pregnancies are classified primarily in relation to how much bleeding is involved, and they are classified generally in this way: A ruptured tubal pregnancy is one in which there is a considerable amount of bleeding involved, but where there is only a small amount of blood, just a little ooze, or something like that, the condition is classified as unruptured, so the distinction in the language is somewhat misleading, rupture and abortion not being the distinguishing feature, but rupture in relation to a large amount of bleeding, and unruptured where there is a small amount.

THE COURT: Without going into all these details, what do you contend the doctor should have done?

13 MR. DOWDEY: The doctor should have repaired the tube instead of amputating it. He should have consulted with his patient. He should have consulted with another physician.

THE COURT: I understand. Well, failure to consult with another physician does not create a cause of action unless you can show that another physician would have given contrary advice.

MR. DOWDEY: The doctor indicated and admitted on his deposition, if the Court please, that this was a matter in which reasonable specialists might differ.

THE COURT: I see. Well now, you claim that he should have repaired the tube. Are you going to show, or attempt to show that it was possible to repair the tube?

MR. DOWDEY: By his own admission, yes.

THE COURT: You are going to show that?

MR. DOWDEY: Yes.

THE COURT: I see. Very well.

MR. DOWDEY: The reason I am taking time with this, Your Honor—

THE COURT: There is no objection to your taking all the time you need, but I am just wondering whether all these details are relevant. The way I understand your cause of action is that your contention is the doctor could have done all that was necessary for the patient by repairing the tube instead of amputating it?

MR. DOWDEY: Yes.

THE COURT: And thereby saving her childbearing function; is that it?

MR. DOWDEY: Basically. That is basically what is involved.

THE COURT: Is there anything else?

MR. DOWDEY: Well, and the consultation with her, non-consultation with her.

THE COURT: Yes, I understand. You know every case comes down to one point, and I always try to pinpoint a case and know what I have to decide.

MR. DOWDEY: Yes.

THE COURT: You may proceed in your own way, but I am just trying to bring the matter to a point. I am not trying to cut you off.

MR. DOWDEY: The reason I am doing this, Your Honor, and it may help you if I explain it, is that this is simply the geography of the land we are going to cover, and it will come up frequently during the course of the trial.

THE COURT: I think you better leave that to the witnesses.

MR. DOWDEY: Well, this is from the witness' testimony.

Now the distinction that is important to make here is between
15 a ruptured and an unruptured ectopic pregnancy. A ruptured ectopic

pregnancy is a very serious emergency, and most ectopic pregnancies that are encountered are ruptured. They are seldom, if ever, found before rupture. It is a relatively uncommon thing to find, as was the case here, the claim that this was an unruptured ectopic pregnancy.

Now this patient had only about less than two years previously had had a ruptured ectopic pregnancy. She had been in Florida and had been taken into the hospital in an acute emergency condition with a ruptured ectopic pregnancy. She was in excruciating pain and she had to have a blood transfusion. There was a consultation and a laparotomy was performed and the tube removed. Because of this experience with a ruptured ectopic pregnancy, which is the typical kind encountered by physicians and laymen alike, she was very apprehensive when she went to Bolling Air Force Base Hospital, although her conditions in no way resembled in acuteness her former experience. Her complaints were fairly mild and limited mostly to cramps and a small amount of bleeding. Her last normal monthly period had been in the first part of January, so that if an ectopic pregnancy were discovered, it would only be of about four or five weeks duration, which is about the shortest time in which they could possibly be discovered.

Now, Dr. Eavey, when she was admitted, said this was not a
16 true emergency.

THE COURT: I do not think it is necessary in opening statement to go to all those details. Bring that out in the evidence. The opening statement is supposed to summarize and clarify what the issues are, and if you summarize the evidence, do it in a very skeletonized fashion. Don't argue the case now.

MR. DOWDEY: I am not arguing it. This is only a matter, if the Court please, since the language and terminology here is somewhat—

THE COURT: I know but you are not talking about terminology now, besides which we will let the witnesses explain scientific terminology.

Now, is there anything else?

MR. DOWDEY: Yes, indeed, Your Honor.

THE COURT: Very well.

MR. DOWDEY: The point is that this—I had a very extensive

opening statement prepared.

THE COURT: Extensive opening statements sometimes are helpful in a jury case, but not in a matter of this kind.

MR. DOWDEY: Very well.

THE COURT: I think you better reserve that for final argument. I will let you have full time for final argument.

MR. DOWDEY: All right. In any event I will say what happened
17 here was that before the operation the doctor told her that she probably had another ectopic pregnancy, and he indicated that if that were the case the tube would almost certainly be removed. He did not explain to her, though—

THE COURT: You said all that before, Mr. Dowdey, that he didn't explain, didn't ask her and didn't explain that he might have to remove her Fallopian tube. There is no use repeating. I understood you the first time.

MR. DOWDEY: I think I covered, then, in the first part of my opening statement the essential questions, and I will not then go through with the descriptive material.

THE COURT: Very well. Miss Bacon.

MISS BACON: May it please the Court, on the basis of plaintiff's opening statement, defendant moves for judgment for three reasons: first, on opening statement he has identified this as an act which took place in 1955 in Bolling Air Force Hospital. The complaint in this case was filed in 1959.

THE COURT: Miss Bacon, I have observed that the pre-trial order, while admitting these dates, states that the plaintiff did not discover the removal of the tube until some time later, and that the date of discovery would bring the matter within the period. It seems to me that is a question of fact which the plaintiff would have to prove. I do not
18 think I ought to dispose of that point on a motion in an opening statement.

MISS BACON: In the course of opening statement, if Your Honor please, this allegation has not been made.

THE COURT: Well, he does not have to make that.

MISS BACON: And I further submit that that allegation will not be made.

THE COURT: Well, it is in the pretrial order.

MISS BACON: If Your Honor please, subsequent to the pretrial order this cause came on for trial before Judge Pine, at which time, in the course of his opening statement, plaintiff's counsel changed and re-identified the allegations which he made. Those allegations, as carefully pinned down and specified in the course of his opening statement, which supersedes this pretrial statement, are as follows.

THE COURT: You say it came on for trial before another judge?

MISS BACON: That is correct.

THE COURT: What happened to the case then? Why is it here?

MISS BACON: At that time he changed his allegations of negligence and the allegations of the pretrial statement. The government was surprised by this change and requested time. The three issues we have
19 here are not with respect to when she had knowledge of this matter. They are as specified: one, making the choice himself in 1955, failure to give this plaintiff the choice in 1955, and failure to consult another physician in 1955. Each of these acts occurred in 1955. Each of them were known or could have been known to the plaintiff in 1955.

THE COURT: I am not going to dismiss this case on the opening statement. This is too serious a matter, Miss Bacon, on that ground. I am going to try that issue as to the statute of limitations, because this is a very serious matter if the facts are as Mr. Dowdey states them to be. I am not prejudging the case, but it is a matter that I ought to pass on the merits instead of treat it cavalierly on a motion to dismiss. Of course in civil actions, motions to dismiss on opening statements are not favored, you know. Of course, I have granted such motions, but that is where it appeared conclusively from the opening statement that there could be no liability.

Now what are your other grounds for dismissal?

MISS BACON: My other grounds are that these three specifications of negligence actually are found in assault and battery and misrepresentation and are outside of the scope of the Federal Tort Claims Act.

THE COURT: I am going to deny that motion. That very same question came up in a recent case in another circuit. It was claimed by
20 the government that this was an assault and battery where a wrongful

operation was performed. It was claimed that there was an assault and battery. That was in the Third Circuit, and the Third Circuit overruled that point and said it is negligence. That involved a very curious situation. One would think it was an impossible situation. The doctor was to operate on one knee of the patient and he operated on the wrong knee and discovered that he was operating on the wrong knee. After he opened up the knee he sewed it up and then operated on the proper knee. This was in a government hospital in Philadelphia, I think it was. I think it is in the Third Circuit, but I am not sure, and it was in the advance sheets within the last few weeks or month or so, and the point was the point you are raising that this was an assault and battery and not malpractice, and that point was overruled.

MISS BACON: I would commend to Your Honor's attention a decision to the contrary in the Eighth Circuit, to wit, Moss versus the United States at 225 Fed. 2d, 705, wherein the operation was to be performed on the right hip—on the left hip, excuse me, and they proceeded on the right hip. The case arises under the Federal Tort Claims Act, held unconsented operation and assault and battery.

THE COURT: I am not going to follow that. I am going to hold this is negligence, but I would like to have the citation of the Eighth Circuit case. In other words, there are cases both ways, and it is open in this circuit, and I am not going to excuse the government on any technicality such as that.

MISS BACON: I would submit that it is not open in this circuit, if Your Honor please, in the light of the substantive law of this circuit on what is an unconsented operation. As we well know, under the Federal Tort Claims Act, you look to the law of the State. In this jurisdiction an operation, I submit, performed in these circumstances is an unconsented operation and is an assault and battery, and that Your Honor should follow in this circuit the case of Bonner versus Moran, 75 United States Appeals D.C., 156.

THE COURT: What does it hold?

MISS BACON: It holds that unless the parents consent to the operation, it is an assault and battery on the child.

THE COURT: Well, that is an entirely different point, isn't it?

This is an operation that was improperly performed, at least the charge here. I do not think this is an assault and battery. I think this is malpractice. I never like to use the word "malpractice" because the word "malpractice" has an opprobrious connotation. I would say negligence.

MISS BACON: If Your Honor please, there is no allegation in this case that this operation was improperly performed. The allegation is that he didn't give her the choice, he didn't give her enough information
22 to permit her to intelligently consent, and in the absence of that consent—

THE COURT: I am not going to dismiss this matter at this juncture. Let me have your Eighth Circuit case.

MISS BACON: Moss—M-O-S-S—versus United States, 225 Federal Report, Second, 705, Eighth Circuit, 1955.

THE COURT: Now, what is your third ground?

MISS BACON: My third ground is, Your Honor, that we have not had a substantial proffer of proof as to the essential elements of plaintiff's case, to wit, the standard of practice in the District of Columbia in 1955.

THE COURT: Well, that is a matter of proof.

MISS BACON: I submit, Your Honor, that when he fails to make any proffer, he has failed, under the Brown versus Keaveny case, to proffer an essential element.

THE COURT: He does not have to make a proffer in his opening statement, Miss Bacon. He indicated in a general way that he was going to claim that it was contrary to standard practice and I rather cut him off not to go into details at this time. No, I am not going to dismiss this case on opening statement. I think it would be a very serious matter. In fact, I think it would be erroneous for me to dismiss it on an opening statement.

Is there anything else before you want to make your opening
23 statement?

If your Honor please, I would also suggest that this case is barred insofar as it is found in misrepresentation under the Federal Tort Claims Act.

THE COURT: I do not understand from the opening statement that actually this is an action for misrepresentation. This is an action for negligence in removing a Fallopian tube.

Is that what this comes down to?

MR. DOWDEY: Yes, Your Honor.

THE COURT: Before I let you make your opening statement, I do want to ascertain if there is any change in the issues. You indicated that there was a change in the issues as a result of an opening statement made before Judge Pine; is that it?

MISS BACON: That is correct, Your Honor. The only issues before Your Honor at this time are: one, whether making the choice himself, if there was a choice, is a negligent act, whether there was failure to give the plaintiff a chance to make a choice.

THE COURT: I think that is a matter of evidence. The question is whether the doctor acted in accordance with proper standards in removing the Fallopian tube. Isn't that the basic question, or do you conceive that something else is the question?

24 MISS BACON: I conceive, Your Honor, that it has to be limited to the question of whether or not, in terms of the standard of practice in the District of Columbia in 1955, in the circumstances of this woman, there was any choice to be made.

THE COURT: I understand, but that is a matter of evidence, isn't it?

MISS BACON: His allegation of negligence is that the doctor made the choice himself.

THE COURT: And the contention is that he had no right, that he made a choice that was fatal because he could achieve the same result by repairing the tube. Now, that is the issue.

Is that correct, Mr. Dowdey?

MR. DOWDEY: Yes, Your Honor.

THE COURT: Very well.

MR. DOWDEY: And the other issues, too, of course.

THE COURT: But how were the issues changed? You indicated that they had been changed from the pretrial order.

MISS BACON: Yes, if Your Honor please, in the pre-trial order you will notice that on the top of page 2 there is an allegation that there was a mutilation which was unnecessary.

THE COURT: Well, exactly, the removal of the Fallopian tube. That is what I understood that was.

25 MISS BACON: That it was done without an adequate consultation with the plaintiff.

THE COURT: I understand, but all these are elaborations of the main issue. The main issue is that he had no business removing the Fallopian tube when he could have achieved the same result without using that drastic measure. That apparently is the issue here.

Is that correct, Mr. Dowdey?

MR. DOWDEY: That is the central issue, yes.

MISS BACON: And we respectfully submit that that was accomplished in 1955 and that the statute began to run then and that if it was done without her consent, it was an assault and battery.

THE COURT: I am going to overrule the contention it is an assault and battery.

But how do you get around the statute of limitations, Mr. Dowdey?

MR. DOWDEY: He had an obligation, if the Court please, to inform her of the choice and he failed to do so, and she did not discover that there was a choice until I took his deposition in 1960.

THE COURT: When did she discover that her Fallopian tube had been removed?

MR. DOWDEY: She knew her Fallopian tube had been removed but she was led to believe that it was a matter of necessity, and that there
26 was no other choice available.

THE COURT: I am not so sure that the statute has not run, but I am not going to decide this on a motion to dismiss on the opening statement. I thought that she did not discover that her Fallopian tube had been removed until later. That would have been a different matter.

MR. DOWDEY: No, she knew that the tube had been removed, but

she was under the impression that it was necessary to save her life and that there was no choice, and he failed to disclose this, although, as Your Honor knows, because of the confidential relationship between patient and physician, he had a duty to make the disclosure.

THE COURT: Yes, I understand that, but when did she discover that there was a choice?

MR. DOWDEY: When I took the deposition in 1960 after this suit had been filed.

THE COURT: I see. Do you mean until then she did not know that there had been a choice?

MR. DOWDEY: That's correct.

THE COURT: Very well. I think it would be a mistake for me not to try this case on the merits.

MISS BACON: In final comment on this, Your Honor, he said she did not discover it until he took his deposition. She could have discovered it in 1955 by asking any other physician.

27 THE COURT: You may be right there, but I think that is a matter of evidence. I think I would be making a serious mistake if I dispose of this on the opening statements. There are cases, you know, that can be disposed of very promptly but there are other cases that ought to be explored very thoroughly, and this belongs to the latter group. You may have a perfect defense, and if you have, it would be a mistake for me to dispose of the case on the opening statement. So I am going to deny your motion, Miss Bacon.

OPENING STATEMENT BY COUNSEL IN BEHALF OF THE DEFENDANT

MISS BACON: May it please the Court, the event which is the subject of this suit occurred nine years ago. The hospital is now defunct, the persons who participated have scattered ---

28 MISS BACON: As I was indicating to Your Honor, that although the hospital is defunct, although persons are scattered and although there have been many intervening developments in the field of medical science, defendant has nonetheless tried to seek out what did occur in 1955 and has sought out witnesses as to what the standard of

practice was in 1955. Through these evidence and the experts, defendants will demonstrate to this Court the following: that there were no equivalent choices in this matter. Plaintiff had an ectopic pregnancy. The proper treatment for it was removal, removal by immediate surgery, that the accepted procedure in the District of Columbia in 1955 was removal by a salpingectomy; i.e., amputation of the tube; that plaintiff is totally in error when she alleges that there were equivalent alternatives, or when she alleges that salpingectomy is only justified to save a life.

The evidence will show that this amputation was the proper procedure in the District of Columbia, that such procedures as shelling out or plastic repair of the tube were essentially experimental procedures primarily reflected in foreign literature, not accepted practice in the District of Columbia.

THE COURT: Do you mean as of 1955?

MISS BACON: As of 1955. Further, we will show that the tube, as found by Dr. Eavey, was not a fit subject for even experimental shelling out. It was bloody and distended, and in a woman with a history of the plaintiff's, repair of the tube would have been to her
29 detriment and not accepted practice in the District of Columbia. Dr. Stafford Hawken, one of the recognized gynecologists and obstetricians in the District of Columbia will testify on behalf of defendant as to the state of practice in the District of Columbia in 1955.

Defendant will further contend that there being no choice in this matter, that whatever selection was made by the doctor was a matter of his professional judgment, and that he is not responsible for any future to communicate a choice to the plaintiff.

THE COURT: Well, if there was no choice he could not communicate it. However, if there was a choice he should have taken the one that involved the lesser evil.

MISS BACON: Yes, Your Honor, but we will call Dr. James Z. Appel, a doctor of Lancaster, Pennsylvania, who will testify on behalf of the Joint Committee for Accreditation of Hospitals in the United States, that the regulation on which plaintiff appears to rely is not

applicable in cases of this nature.

THE COURT: There was no regulation stated. What regulation are you referring to?

MISS BACON: My recollection of plaintiff's opening statement was that he said regulations which bind all accredited hospitals require a consultation among physicians in cases of this nature.

30 THE COURT: I may have misunderstood. I thought he meant that the practice was a matter of regulation.

MISS BACON: Dr. Appel will testify that it is neither practice nor custom to consult in these matters.

We will further show to Your Honor that this was not, as plaintiff suggests, a sterilization or a procedure to prevent contraception, and that talking about this case in these terms is pure emotionalism. This was a matter which needed prompt attention.

THE COURT: Of course I can see where there would be an emotional feeling in a case where a young woman is deprived of her childbearing function by an operation. I can conceive the emotional overtones.

MISS BACON: We are indeed cognizant of those emotional overtones, Your Honor, and are appreciative of them, but we submit that plaintiff's inability to now have children is a collateral result of necessary surgery, that it is a result of what she knew in 1955. It is a result of which she only complains belatedly now in her complaint of 1955. We therefore submit that performance of this salpingectomy was proper in this case.

THE COURT: What is the name of that operation, the technical name?

31 MISS BACON: Salpingectomy.

THE COURT: I thought I should have the scientific name now that we are going to discuss the matter.

MISS BACON: That will conclude the opening remarks, and I did probably not mention one additional witness that we would have or may call, a Dr. Kenneth Morrissey of the Air Force Surgeon General's Office.

THE COURT: Very well. Mr. Dowdey, you may proceed.

MR. DOWDEY: Before doing so, Your Honor, I have the names here that have been mentioned in the opening statement of at least two witnesses whose names I never heard before, and I would—I don't want to interrupt the trial—I would request, however, that I be furnished with a copy of any statements these men may have furnished.

33 MISS BACON: We did give him such an additional witness by letter subsequent thereto, to wit, Dr. Kenneth Morrissey. The only new witness at this time is Dr. James Z. Appel. He comes as a rebuttal witness to the allegations that the regulations require consultation. No statement has been obtained from him.

MR. DOWDEY: Very well.

Do you have a statement from Dr. Morrissey:

MISS BACON: No.

MR. DOWDEY: Very well.

THE COURT: You may proceed, Mr. Dowdey.

MR. DOWDEY: I would like to introduce at this time the deposition of Dr. Eavey, which also contains, I believe attached to it, all of the medical records of the hospital.

37 THE COURT: Mr. Dowdey, before you proceed with the deposition, I was thinking over a little more during the luncheon recess that statute of limitations.

Will you tell me again how you propose to meet that defense.

MR. DOWDEY: The situation, if the Court please, is that she was not informed of this choice that the surgeon had, although he had an obligation to tell her, and she didn't discover, therefore, that the heart of the matter, as Your Honor has pointed out, namely that he had a choice, that it wasn't necessary to save her life.

THE COURT: I understand, but how do you meet the defense of the statute of limitations? Let's assume that all you say is true, that the government claims that the surgeon acted in accordance with the established practice as of that particular time in the District of Columbia. You claim he did not, but that he could have done something else

than taking out the Fallopian tube, but you have not answered my question.

How do you propose to meet the defense of the statute of limitations?

MR. DOWDEY: Because she didn't discover the wrong that was done until later.

THE COURT: Let's see. The wrong that was done was in taking
38 out the tube. Now she knew that the tube had been taken out.

MR. DOWDEY: Right.

THE COURT: I think you would have a good rejoinder to the defense of the statute of limitations if the fact was that she didn't discover that the Fallopian tube was taken out until later, and of course that sort of possibility may arise. You take those sponge cases in the wounds where it was discovered a year later that there was a sponge in the wound. I would say that the statute of limitations begins to run when the presence of the sponge was discovered, but here she knew that the tube had been removed. All you say is that she did not realize, that according to your theory, according to your contention, she could have been properly treated and her condition cured without removing the tube.

MR. DOWDEY: That's right.

THE COURT: That is not discovering the existence of a cause of action.

MR. DOWDEY: I think it is, Your Honor, and I can present, if the Court please—I have memoranda on this.

THE COURT: If you have a memorandum you better let me have it. I will look at it over night. I wanted to clarify my thinking and I want to tell you right now that I have grave doubt as to whether, on the basis of the contention that you now make, you can meet the defense of the
39 statute of limitations, but I am not going to dispose of this case on a statement by counsel of what they contend.

MR. DOWDEY: Yes.

THE COURT: I think we better take the evidence as long as the case is ready for trial, and I think we better have just one trial instead of rather a possibility of several trials.

MR. DOWDEY: May I say this, just before going on, that the point which Your Honor raised was submitted on a motion for summary judgment here before Judge McGarraghy, and it was extensively briefed at that time, and Judge McGarraghy ruled in our favor. Now the point that I would like to make here, in addition to the many authorities cited in the memorandum before Judge McGarraghy, since then the principal authority upon which the government relied at that time has been reversed, and I can give you that citation which will bring my previous memoranda right up to date.

THE COURT: What is your citation? Did Judge McGarraghy write a memorandum?

MR. DOWDEY: No, he did not, but the matter was extensively briefed.

THE COURT: Of course, you know a denial of a motion for summary judgment is not res judicata.

MR. DOWDEY: I understand that. I am simply referring to the
40 memoranda and trying to bring those memoranda up to date with this one case.

THE COURT: I do not want a series of memoranda on the same subject. I think you better bring it down to date and let me have one memorandum.

MR. DOWDEY: Right.

THE COURT: Now what is your citation.

MR. DOWDEY: It is Hungerford—against U.S., and it is in the Ninth Circuit, 307 Fed. 2d, 99.

THE COURT: And what does it hold?

MR. DOWDEY: And that holds that the—I will quote: "A claim for malpractice accrues against the government when the claimant discovers, or in the exercise of reasonable diligence should have discovered, the act constituting the alleged malpractice."

THE COURT: I do not see how that statement helps you. That would be applicable if the plaintiff did not know that the tube had been removed, and she might not have known, they sewed her up. The average patient, when he comes out of the operating room, does not know what has been removed from his body or not removed, but that does not

stem from the proposition, does it?

MR. DOWDEY: I think it does, Your Honor.

41 THE COURT: That if the person knows what was done to him but does not realize that it wasn't necessary. The cause of action arises when he first realizes that it was necessary.

MR. DOWDEY: Because that itself is malpractice. Not telling them is malpractice. That is the point, Your Honor. I quite see the point that you are making, that ordinarily in this class of cases when the injury is discovered would be the time. However, where in a case there is affirmative duty, the failure to inform the patient of choices is itself malpractice.

THE COURT: Mr. Dowdey, you cannot jump all over the lot. I asked you how do you propose to meet the defense of the statute of limitations, and first you tell me one thing, and I expressed doubt as to its sufficiency. Then you talk about something else.

Now how do you propose to meet the defense of the statute of limitations?

MR. DOWDEY: I am not aware that I told you something else, Your Honor. I have said there is a duty to make a disclosure, and the failure to make that disclosure of choices or diagnostic material is itself malpractice.

THE COURT: If it is malpractice it is barred by the statute of limitations, because the failure to make a disclosure took place more than two years prior to the commencement of the suit.

42 MR. DOWDEY: But you don't know that there was a failure of disclosure until you cross-examine the man and find out that there was something he should have communicated, and therefore it was not discovered.

THE COURT: I think it would be worthwhile for me to decide all of the issues in this case instead of letting you go off on any one issue, but I have grave doubt so far as the plaintiff is concerned on the issue of the statute of limitations, and I would be very glad to have a memoranda from you, but don't hand me an old memorandum and then someone else has to bring it down to date. You bring it down to date yourself and give me just one memorandum.

44 MR. DOWDEY: I am offering the deposition * * * of James L. Eavey, which was taken in Florida in December of 1960 in this case.

THE COURT: Very well. Now then I am going to read the portions as you offer them, and Miss Bacon, whenever you have any objections as we come to those portions, you may interpose your objections.

MR. DOWDEY: Page 2, then, would be line 6 to 16.

MR. DOWDEY: Page 3, line 16 to the bottom of the page, all of page 4—

THE COURT: Well now, just a moment, because I am going to read this as we go along. Page 3 starts on line 16; is that right?

MR. DOWDEY: Yes, Your Honor.

(The indicated portion of the deposition was read by the Court.)

THE COURT: Now all of page 4?

MR. DOWDEY: All of page 4, 5, 6 and 7, but not all of 7.

MR. DOWDEY: Before we go to that, the witness changed, line 22 on page 6, where it says the year "'50," he struck out "'50" and inserted "July."

46 THE COURT: Instead of '51?

MR. DOWDEY: No, he struck out the "'50," the year "'50," and made it "July" instead of "'50." So it should read, "the year July '52 until June '53."

THE COURT: Very well.

MR. DOWDEY: Page 7 down to line 22.

MR. DOWDEY: Page 8 beginning at line 24.

MR. DOWDEY: And the next pages, pages 9 through 23—

THE COURT: Very well.

MR. DOWDEY: (Continuing)—and ending at the top of page 24 with line 3.

MISS BACON: We would object to those portions of the deposition because they relate only to his past experience in diagnosing this type of situation. There is no allegation that he was improperly qualified.

47 THE COURT: I think this is admissible to show his background.

(The court continued to read the indicated portion of the deposition.)

Miss Bacon, I do think there is a good deal of repetitious material in those pages, but I will let it in rather than go through and excise the repetitious material. Some of the terms are not familiar to me and I wonder if we can agree upon them.

What is colpotomy? Is there any controversy over what it means?

MR. DOWDEY: Colpotomy is explained subsequently.

THE COURT: I beg your pardon?

MR. DOWDEY: It is explained subsequently by reference.

THE COURT: No, answer my question. Can you tell me what it is in a sentence? Can you, Miss Bacon?

MISS BACON: Yes, Your Honor. I have the definition from Blackiston's New Gould Medical Dictionary. Colpotomy is defined as a surgical incision of the vagina.

THE COURT: What kind of an incision?

MISS BACON: Surgical incision of the vagina.

48 THE COURT: And what is laparatomy?

MISS BACON: Laparatomy is a surgical incision of the abdominal area.

(Short pause in the proceedings.)

THE COURT: Now, I am up to line 3 on page 24. What is next?

MR. DOWDEY: Very well. The next begins with the last line on page 25, line 25, and goes through page 30, but I would like to say that the witness made a correction there which you might want to make before you start reading.

THE COURT: Where is the correct?

MR. DOWDEY: And that is on page 27, line 28.

THE COURT: And what is the correction?

MR. DOWDEY: The last two words on that line "are through" were stricken out and the word "perforate" substituted.

THE COURT: Page 27, what line?

MR. DOWDEY: Line 18, the last two words in the line are "are through."

THE COURT: Yes.

MR. DOWDEY: They were stricken out and the witness substituted the word "perforate."

MISS BACON: I would have objection, Your Honor, beginning on 49 line 20 of page 26. The question is: "Is it safer as regards the risk of infection, Doctor?" I say that question is not relevant, and the line of questions following thereafter are not relevant for the reason that there is no issue here that the procedure he chose resulted in infection.

THE COURT: Well, I won't take this because that is a question really of substantive law rather than the law of evidence. If it turns out to be irrelevant, then of course I won't consider it.

MISS BACON: We, of course, in a non-jury trial rely on the Court to exclude that which is immaterial and irrelevant and of no evidentiary value.

THE COURT: Before we proceed I want to ask you a question, Mr. Dowdey. Now, the operation involved in this case is known as salpingectomy. Now I notice that the testimony that you have been of- 50 fering in evidence relates to all types of operations, doesn't it, laparatomy, and something else?

MR. DOWDEY: They are all terms—

THE COURT: How does that bear in the question here involved?

MR. DOWDEY: Because if surgical repair was done, it would ordinarily be done by laparatomy, which is an incision through the abdomen, whereas this technique that he used was a very novel technique. The ordinary way to proceed would be by laparatomy, as you will see.

THE COURT: Is it your contention that he should have performed

a laparatomy instead of a salpingectomy; is that it?

MR. DOWDEY: They aren't different; laparatomy is merely the kind of incision made.

THE COURT: I see. Very well.

MR. DOWDEY: Salpingectomy is the removal of the tube.

THE COURT: I see.

51

MR. DOWDEY: We resume at page 43, at line 18, to page 45, line 15.

THE COURT: Yes Miss Bacon?

MISS BACON: I have objection, Your Honor, on the ground that this is not relevant to the case.

THE COURT: Just what part are you referring to?

MISS BACON: I am referring beginning with the question on line 18, page 43. They are general questions with respect to the presence or absence of decidual tissue in a laboratory report. There is no contention in this case that the laboratory report—

THE COURT: I am not going to pass upon the questions of substantive law really. I have to take the evidence and then decide the case. I cannot dismiss the case without first taking the evidence, you know, and I cannot decide a case in advance in order to determine what evidence to take. I am going to take the evidence. The only type of objection that is really proper is if there is any law of evidence that is violated like hearsay or something of that sort.

MISS BACON: I would respectfully submit, Your Honor, that we have only three issues in this case.

THE COURT: I said I am going to overrule the objection. I am
52 going to take the evidence and then decide the issues. You know, the Court cannot always tell whether a particular question will bear on an issue. Sometimes things develop later and I think it is a mistake to exclude evidence merely because one is not sure whether it is going to bear on an issue or not.

(The indicated portions of the deposition were then read by the Court.)

Actually I have grave doubt as to whether much of what I have

already taken is going to bear on the issue because as I understand what is the question, it is whether he had a right to perform an operation.

MR. DOWDEY: That is one of them. There are other aspects of it, as Your Honor has pointed out. There are other matters surrounding.

THE COURT: There is the statute of limitations, yes.

MR. DOWDEY: And the duty to inform her.

THE COURT: Well, that is part of the operation. Even if he had to perform the operation and he had the patient on the operating table, why it would have been silly to have sewn the patient up and wait until the patient came out from under the anesthetic and then consult the patient.

MR. DOWDEY: But as you will see later in the deposition, Your Honor, this was a possibility before he started opening.

THE COURT: Yes, I know, but that issue, too, is not affected by
53 most of this testimony.

Now we are down to page 45, line 15. What is next?

MR. DOWDEY: Page 46, line 10 through 25.

THE COURT: You may proceed.

MR. DOWDEY: Skip 48 and on 48 we begin at line 13 through 49 to the bottom of the page.

THE COURT: Very well.

MR. DOWDEY: We skip page 50 and starting on 51 at line 19, we continue—* * * through 54, line 13.

THE COURT: Very well, just a moment.

(The indicated portions of the deposition were then read by the Court.)

Now on page 52 we seem to get to the crux of the matter, namely what a Doctor did.

MR. DOWDEY: That is correct, and may I say this, Your Honor, you will notice that he refers to Exhibits A1- through A-43, and so forth.

THE COURT: Yes.

MR. DOWDEY: I would like to offer those, although I will say this, that I think most of what is involved in those is described here by the

54 files, but I think they should be in the record.

THE COURT: Well, are you offering it or not?

MR. DOWDEY: Yes, I am.

MR. DOWDEY: Very well, and we skip 55 and begin with line 19 on page 56, and continue through to line 13 on page 61, and Dr. Eavey made one correction in that part on page 59.

(The indicated portions of the deposition were read by the Court.)

Now I am on page 59.

MR. DOWDEY: Line 6, the sentence beginning on that line begins, "A procedure" should be "The procedure."

THE COURT: Yes, thank you.

55 Now, I want to go back to where the witness describes the operation at some length.

Where is the part where he describes, or is there a part where he describes the removal of a tube?

MR. DOWDEY: I think it is at page 57. I think he describes it very briefly there.

THE COURT: I know, but where does he describe the removal of the tube?

MR. DOWDEY: He says, "The tubal pregnancy was removed by clamping . . ."

THE COURT: I saw that. He says the pregnancy was removed. Does that necessarily mean the tube itself was removed?

MR. DOWDEY: He says, ". . . by clamping and ligating the mesosalpinx at approximately the mid-portion of the tube proximal to the tubal gestation." There is more in the record, however, that makes it—

THE COURT: Not in this testimony.

MR. DOWDEY: Not right in here.

THE COURT: Very well. Well now, we are down to page 61. What is next?

MR. DOWDEY: Page 62 beginning at line 20 through page 74, line 1

56 THE COURT: I am wondering about the relevancy of the material on page 63, what Army posts had facilities for any—

MR. DOWDEY: The availability of consultants.

THE COURT: I think the Court can take judicial notice of the fact that there are a good many hospitals in this city. I think a lot of this is surplusage.

MR. DOWDEY: That may be but he gets down to specifics right after that, Your Honor, about precisely who was available and how they could be reached.

THE COURT: Well, I will take judicial notice that there are plenty of skilled physicians and surgeons in every branch of medicine and surgery in the metropolitan area.

MR. DOWDEY: All right. In that case I think we can skip to page—I think we can skip to page 66, line 19 onward.

THE COURT: Yes, and what then?

MR. DOWDEY: And continue through to 71.

THE COURT: Very well.

(The indicated portions of the deposition were read by the Court.)

Very well, what is next?

57 MR. DOWDEY: We skip to page 75, beginning at line 18 through page 82, line 20.

(The indicated portions of the deposition were then read by the Court.)

MISS BACON: I have objection when Your Honor arrives at page 77.

THE COURT: Very well, if you will just bear with me a moment.

I am on page 77, Miss Bacon.

MISS BACON: The question on line 2, the question does not specify whether the year is 1955 or the year of the deposition. I therefore object because it is not relevant to the availability of techniques in 1955.

THE COURT: This deposition was taken in 1960, only five years

later. Well, I will let it stand. I think the testimony is vulnerable. For that reason I do not think it is inadmissible.

MISS BACON: This same objection and I assume Your Honor's same ruling would go to the questions on page 78?

THE COURT: You see, I have this in mind. This is not a situation where I can say to counsel, well, you better reframe your question. The witness is not here, but I can take into consideration and you can point out in your final argument the vulnerability of any of these answers.

58 But, however, it was helpful to call attention to the matter.

(The Court continued to read the indicated portions of the deposition.)

I am to page 82 as indicated.

MR. DOWDEY: Now on page 80 the witness changed and struck out a phrase in the question, in his answer on line 13. The words he struck out are "and you do immediately" on line 13, page 80.

THE COURT: Very well, I have it. Now, where at page 82, what is next?

MR. DOWDEY: Page 83 beginning line 17 and continuing through to page 86, line 18.

(The indicated portions of the deposition were then read by the Court.)

THE COURT: I am through 86. What is next?

MR. DOWDEY: Page 87, line 6, through page 91, line 21.

THE COURT: Line what?

MR. DOWDEY: Line 21 on page 91.

THE COURT: Yes.

(The indicated portions of the deposition were read by the Court.)

What is next?

MR. DOWDEY: On page 92, line 11 to line 21, and that is preliminary to—

59 THE COURT: Yes.

MR. DOWDEY: And that was reframed, that same question was reframed beginning, but making reference to it, on line 13, page 93, and continuing through page 96 to line 21.

(The indicated portions of the deposition were read by the Court.)

THE COURT: Very well.

MR. DOWDEY: The witness changed some of his language on page 94, line 16. Just before the last word he inserted the word "but" on line 16, so it reads, "but would certainly have to . . . "

THE COURT: I have it. Thank you.

MR. DOWDEY: Lines 18 and 19—at the end of line 18 he struck out the words "beginning, is compatible with . . . " In other words, he struck out the phrase, ". . . a beginning is compatible with . . . "

THE COURT: ". . . a beginning, is compatible with having its beginning . . . " Very well.

MR. DOWDEY: We skip then to page 99, line 9, to page 100, line 12, and I wanted to draw your attention to the fact that this is examination by Mr. Hannon.

THE COURT: That would not make any difference. You are adopting it by reading it into the record as though it were your own.

60 (The indicated portions of the deposition were read by the Court.)

Very well, what is next? Is there any more?

MR. DOWDEY: Beginning on the same page 100 at line 23 through page 103, line 3.

(The indicated portions of the deposition were read by the Court.)

THE COURT: Is there anything more?

MR. DOWDEY: And page 104 beginning at the last line on page 104 through line 13, page 105.

(The indicated portions of the deposition were read by the Court.)

THE COURT: Is there anything more?

MR. DOWDEY: Page 106, lines 1 through 10.

(The indicated portions of the deposition were read by the Court.)

THE COURT: Very well.

MR. DOWDEY: Page 107, lines 1 through 19.

(The indicated portions of the deposition were read by the Court.)

THE COURT: Is there anything more?

MR. DOWDEY: Page 108, line 10 through to the end of the deposition at 114, line 22.

(The indicated portions of the deposition were read by the Court.)

61

MISS BACON: On page 113 the question begins on line 9; specifically on line 13 the question asks, "... the possibility of some other gynecologist disagreeing with you?" I respectfully submit that possibilities are not admissible evidence.

THE COURT: Yes, I am going to sustain objection to that. I will strike the answer.

MR. DOWDEY: Your Honor, the defendant would like to call a witness out of turn, and preliminary to that witness coming in, I would like to offer this document about which he will testify.

THE COURT: Very well.

MR. DOWDEY: And so I would like to number it Plaintiff's Exhibit 2, because I have some others that will be numbered 1.

62 THE COURT: Very well.

THE DEPUTY CLERK: Plaintiff's Exhibit No. 2.

(Certified Copy of Standards for Hospital Accreditation, 1953, was marked Plaintiff's Exhibit No. 2, for identification.)

MISS BACON: If Your Honor please, we have objection to the admissibility of that document as I have just seen it—

THE COURT: What are you offering in evidence, Mr. Dowdey?

MR. DOWDEY: These are the published standards of the American Hospital Association with respect to consultations and so forth.

THE COURT: Very well. Now, I will hear your objection.

MISS BACON: If Your Honor please, that document purports to be standards dated 1953. At a meeting in December of 1954 the Board of

Commissioners established standards different than the ones contained in the document before you.

THE COURT: Well then you offer that.

MISS BACON: And I further submit that those documents have not been shown to be relevant, material or in fact the standards of the American Hospital Association for accreditation.

THE COURT: Make your objection a little more precise.

MISS BACON: My objection is that they are not—the standards before you are not material and relevant to this case because they were not in effect at that time.

THE COURT: Well, that is a matter of proof. You know, you can only offer one item at a time. I will overrule that objection, but is there any other?

MISS BACON: There has been no formal proof that that document which is before you are the standards of the Commission on Hospital Accreditation.

THE COURT: What do you mean by that?

MISS BACON: There has been no one here to say that those are their standards. That document has no sponsor.

THE COURT: I am going to sustain that objection. To put it a little more pointedly, I think someone ought to testify to this and be subject to cross-examination, Mr. Dowdey. It is like offering a text book in evidence.

MR. DOWDEY: No, Your Honor, these are the published standards. I hadn't qualified them because I had not anticipated this objection.

THE COURT: I do not care whether they are published standards or not.

MR. DOWDEY: Well, the point is that they were published and that's what gives them there—

THE COURT: No, the fact that something is published in print does not make it competent in evidence. Someone has to testify to this, just like every once in awhile somebody, in the question of insanity, will refer to the American Psychiatric Manual. I always exclude it. That is a text book. This is a text book.

MR. DOWDEY: This is not a text book, Your Honor.

THE COURT: Now, what particular provision do you rely on?

MR. DOWDEY: I am unprepared for this, because—

THE COURT: I beg your pardon?

MR. DOWDEY: I am unprepared because I didn't realize there would be an objection here. Just a moment.

THE COURT: Well, I won't admit it anyway without an objection unless you tell me what portion of the document you rely on.

MR. DOWDEY: Very well.

THE COURT: I might as well admit a telephone book in evidence.

MR. DOWDEY: All right. You will notice on page 3—this is published standards, where it says "Required," page 3.

THE COURT: What particular standard do you refer to? Now, here they relate to fire protection and things of that sort. I want to know what you claim is relevant to this case.

MR. DOWDEY: The standard we refer to is on page 7, paragraph 65 3, which are consultations.

THE COURT: I do not think this is a competent method of proving the standards. I think you need oral testimony. I am going to sustain the objection on that ground.

MR. DOWDEY: Well, she has the head of this society here, so we can put him on the stand and proceed.

THE COURT: Well, I do not invite any comment. I have ruled.

MR. DOWDEY: Do you want to call him? Yes, I will call him. What is his name? What is your doctor's name?

MISS BACON: Dr. James Z. Appel.

THE COURT: Do I understand that defense wants to call a witness?

MR. DOWDEY: I put these in to permit their witness to testify, Your Honor.

MISS BACON: If Your Honor please, we brought this witness here to testify if that document were admissible.

THE COURT: I see.

MISS BACON: As long as the document is not admissible we have no desire for his testimony.

THE COURT: Very well.

MISS BACON: He is now being called as plaintiff's witness; is that correct?

THE COURT: Yes, the plaintiff is calling this witness then.

66 MR. DOWDEY: Yes, I will call him.

MISS BACON: I believe the plaintiff has made no arrangement for his testimony or accommodation of his expertese here.

THE COURT: There have been no arrangements for what, Miss Bacon?

MISS BACON: For the expert testimony of this witness.

THE COURT: Well, I don't think that that is a matter with which the Court should concern itself. I think that is a matter between the witness and counsel.

MR. DOWDEY: Will you take the stand, please, sir.

Whereupon,

DR. JAMES Z. APPEL

called as a witness by the plaintiff, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. DOWDEY:

Q. Will you state your name, please? A. I am Dr. James Appel.

Q. And are you associated with the Joint Commission on Accreditation of Hospitals? A. I am.

Q. And in what capacity? A. I am the Chairman of the Commissioners.

THE COURT: What Commission?

THE WITNESS: The Commissioners of the Joint Commission on Accreditation of Hospitals.

THE COURT: Before you proceed, what is that Commission? Is that a governmental commission or is it a committee established by hospitals?

THE WITNESS: This is a corporate body that has been organized by four medical hospital organizations; namely, the American Hospital Association, The American College of Physicians, The American College of Surgeons, and The American Medical Association. There are

twenty commissioners which are divided, seven representing the American Hospital Association, seven representing The American Medical Association, three from American College of Physicians, and three from American College of Surgeons.

THE COURT: Doctor, may I ask you again what is the name of the Commission?

THE WITNESS: The Joint Commission on the Accreditation of Hospitals.

THE COURT: Accreditation of hospitals?

68 THE WITNESS: Yes, sir.

THE COURT: Thank you.

BY MR. DOWDEY:

Q. Doctor, I am about to show you what has been marked Plaintiff's Exhibit 2, for identification. Will you tell us, please, sir, what that is?

A. It seems to have a copy of the Standards for Hospital Accreditation that was published in December 1953. That is the document on the front.

Q. Right. And you recognize those as the standards promulgated by your organization? A. In 1953, yes, sir.

Q. All right. Now when were they published after that? When was the next set of standards published? A. I can't give you the exact date in which the entire standards were published.

THE COURT: I beg your pardon?

THE WITNESS: I cannot give the exact date on which an entire copy of the standards were published. I know the latest one was about 1960, but what is the custom of the Joint Commission is we continually study these standards and from time to time amend certain portions thereof.

BY MR. DOWDEY:

69 Q. And when are they published? A. When there are sufficient amendments that require republishing of the entire standards, they are republished with the new amendments incorporated. I think 1957 was the next time that they were published. I am not sure.

Q. I will help you out on that, Doctor, in just a moment.

THE DEPUTY CLERK: Plaintiff's Exhibit No. 3, for identification.

(Certified copy of Standards for Hospital Accreditation, 1957, was marked Plaintiff's Exhibit No. 3, for identification.)

BY MR. DOWDEY:

Q. I am about to show you what is marked Plaintiff's Exhibit 3, for identification, Doctor.

MR. HANNON: May we see it?

MISS BACON: May it please the Court, these were not marked at pretrial. I would like an opportunity to look at it.

THE COURT: You cannot do it now. You can do it when they are offered in evidence. They are just tendered to the witness.

(The exhibit was handed to the witness.)

THE WITNESS: Yes.

BY MR. DOWDEY:

Q. And is that the next one that was published, Doctor? A. To my 70 knowledge, it is.

Q. And that is what date? A. 1956, January.

Q. And between the first publication or the publication of 1953 and the 1956 publication, these amendments were more or less in the busom of the Commission; is that correct? A. They were published in the bulletins of the Commission that come out periodically.

Q. I see. But these are the only publications of the whole text; is that correct? A. That is correct.

Q. Doctor, do you know, or is it a fact that most all the hospitals in the District of Columbia, both public and private, were accredited in 1955?

THE COURT: Well now, I do not see that that has anything to do with this case.

MR. DOWDEY: I think it does.

THE COURT: Well, I say it hasn't. We are not interested in any other hospital but the particular hospital in which this operation was performed.

MR. DOWDEY: If the Court will hear me on this point, it is to

demonstrate that these standards were applicable in the District of Columbia.

71 THE COURT: I am going to say right now this is not a competent way to prove standards, unless the government has no objection. The way to prove standards is to call an expert witness who will testify what the accepted practice was, and not to prove a publication of an organization, no matter how eminent it may be.

MR. DOWDEY: If the Court will hear me on this point, I would like to qualify these documents.

THE COURT: Oh, yes, you may qualify the documents. Well, you have laid the foundation for the documents. Now I am going to exclude the question about how many hospitals are accredited.

MR. DOWDEY: I offer these standards into evidence.

THE COURT: Now you may show these documents to Miss Bacon.

(The exhibits were shown to defense counsel.)

MISS BACON: I have an objection, Your Honor.

THE COURT: What is it.

MISS BACON: Relevancy and materiality in that there is no showing that either of these documents were the standards applicable in February of 1955.

THE COURT: I am going to overrule that because one is two years before and another two years afterwards, and I don't suppose they publish a new standard every month. I am going to overrule that objection.

72 MISS BACON: I respectfully submit that his testimony has stated that by bulletin they make amendments.

THE COURT: Now, I am going to overrule that objection. That goes to the probative value.

Is there any other objection?

MISS BACON: I further object that there has been no testimony that would apply either of these documents to the hospital involved, to wit, Bolling Air Force Hospital, and they are therefore irrelevant on that basis.

THE COURT: I have indicated why I thought they were not admissible, but you do not adopt that objection. The objection that you have made I shall overrule.

MISS BACON: I further submit, Your Honor, that this is not competent proof of the standards applicable in the District of Columbia.

THE COURT: Objection sustained. The way to prove professional standards—it is not so much professional standards, but the practice usually followed, which may be different from standards—and the way to prove that—we have that in every malpractice case—the expert witness, the expert in the particular field is called who will testify to what, during a particular period and in a particular locality, the customary practice was in regard to a particular matter. You do not prove it by offering a book in evidence.

73 MR. DOWDEY: May I proceed to qualify it then?

BY MR. DOWDEY:

Q. Doctor, in order for hospitals to be certified, they have to comply with these standards; is that true? A. They have to be surveyed by a representative of the Joint Commission and then they must satisfy sufficient of those standards that in looking over the total picture, the Commissioners of the Joint Commission feel that this hospital—

THE COURT: Will you pardon me for interrupting, Doctor. I am going to exclude that question. The hospital is not a defendant in this case.

MR. DOWDEY: I believe it is.

THE COURT: The question is whether the Doctor in this case was following the prescribed or the accepted standard in his profession, in his field, at the particular time in the particular locality, and for that reason I am going to exclude this question.

MR. DOWDEY: I would like to make a proffer then of this testimony. I would like to proffer this testimony then and make a record of it, if the Court please.

THE COURT: Well, make a statement as to what you are proffering.

MR. DOWDEY: I would like to prove by this witness that these standards, at least some of them, not all of them, but the ones that are
74 involved here, are conditions precedent to accreditation of hospitals.

THE COURT: I shall adhere to my ruling, because accreditation of hospitals is not involved in this case.

MR. DOWDEY: It is in this way, Your Honor. The defendant is a hospital. The Government of the United States was operating the hospital.

THE COURT: Well, I understand. I have ruled, Mr. Dowdey. The question is whether the doctor involved in this case was negligent.

MR. DOWDEY: But the standards by which he is judged is the rule of consultation.

THE COURT: Now, just a moment. Do not say "but" to the Court. I have ruled, Mr. Dowdey.

MR. DOWDEY: I would like to—

THE COURT: Now I have told you once before—twice I think—the proper way to prove accepted standard practice.

Now, gentlemen, we are going to recess until tomorrow morning. The Doctor will have to come back if you need more of his testimony.

75 MISS BACON: If Your Honor please, I think it should be clear on the record that the government is not responsible for keeping Dr. Appel here for tomorrow morning.

THE COURT: I think the facts speak for themselves. You have not called him as a witness.

MISS BACON: That is correct.

(Whereupon, at 3:40 P.M. an adjournment was taken until 10:00 A.M., Wednesday, April 15, 1964.)

78 THE COURT: Before proceeding with the case on trial I want to say something that I had intended to say yesterday but I had overlooked. Following my usual practice in non-jury cases when there is a claim for money damages, I will try the issue of liability first, so that I want all evidence of damages withheld for the time being. If I find that there is no liability, then no time will be spent hearing the evidence on damages. If I find there is liability, then we will forthwith proceed to take the evidence on damages.

You may proceed, Mr. Dowdey.

MR. DOWDEY: I would like to say that Dr. Appel is not here this morning for the following reason: that after recess yesterday afternoon Government counsel advised him that he need not return today. I tried to persuade him to do so; however, he would not.

THE COURT: Well, where is he?

MR. DOWDEY: He is in Lancaster, Pennsylvania.

THE COURT: You had a right to serve him with a subpoena.

Did you wish to make a statement, Miss Bacon?

MISS BACON: I wish the record to accurately state that—

79 THE COURT: No; state what you want to the Court and not to the notebook. What do you wish to state to the Court?

MISS BACON: I wish to state to the Court that the United States gave the following advice to the Doctor: that he was under no obligation to the United States to return to this Court as their witness.

THE COURT: There is nothing wrong about that.

MR. DOWDEY: Well, his absence was not procured by me, Your Honor, but by the Government, as far as I can see.

THE COURT: You had a right to serve a subpoena on him. I really think he should have stayed, but that doesn't affect my view that what Miss Bacon informed me was entirely right.

MISS BACON: I would also wish to inform the Court, as Dr. Appel stated in the presence of both counsel, that he had surgery scheduled for this morning and it was impossible to make other arrangements.

THE COURT: Not at all. That is something that doctors seem to not realize. Obedience, response to court process takes precedence over professional engagements. Now of course if a doctor is on his way to court and he sees somebody in an accident and has to render first aid and he is delayed in appearing in court, that is different, but he just
80 has to rearrange his schedules of operations. I have been confronted too often, and my colleagues have, especially in the trial of personal injury cases, of counsel saying my doctor can't come tomorrow because he has an operation scheduled. My answer always is he will have to change his schedule, the Court won't change its schedule.

All you had to do was to serve a subpoena on him, and you not having subpoenaed him, the Doctor was entirely within his legal rights certainly, perhaps moral rights, but certainly he was legally within his rights.

Now what is it that you wished to prove by him? Perhaps it can be stipulated.

MR. DOWDEY: I am afraid it couldn't be stipulated.

THE COURT: Well, what is it that you wished to prove by him?

MR. DOWDEY: The only thing was I wanted to establish certain other things. I don't think it will be necessary to go into this because the matters that were objected to yesterday I think I may be able to connect them up by subsequent testimony.

THE COURT: Very well. I think perhaps it might be helpful, I don't know, if I enlarge and clarify my explanation of my ruling yesterday.

It is not competent evidence of what a particular professional
81 practice is in respect to a particular matter to put in evidence a treatise or a textbook indicating that such and such is the practice, no matter how authoritative in the profession that book may be, and the same is true of resolutions of a professional body. For instance, a resolution of the American Medical Association to the effect that the following practice should be followed in the following matters would not be admissible as proof of the practice because what is proof of professional standards is proof of what is actually being done.

One difficulty about introducing a publication in evidence is that the person that wrote the publication is not here for cross-examination. The other thing is it is the opinion of a writer or an editor or compiler of a book rather than evidence as to what the actual practice is.

Now I have had occasion to rule the same thing in other malpractice cases. There is nothing novel in this.

MR. DOWDEY: I think I may be able to show some subsequent evidence that will make these relevant. However, I will proceed with the rest of the case at this time.

THE COURT: You may proceed.

MR. DOWDEY: Will you mark these?

May I say to the Court that to keep the exhibits straight we will make the depositions Plaintiff's Exhibit 1.

82 THE COURT: No, depositions are not exhibits. They take the same status as though they were read in evidence. They are not marked as exhibits.

I do want to say to you that you stated that there were exhibits annexed to the deposition.

MR. DOWDEY: Yes.

83

(Hospital records of plaintiff marked Plaintiff's Exhibit No. 1-A for identification; Hospital records of plaintiff marked Plaintiff's Exhibit No. 1-B for identification; Sketch attached to deposition of Dr. Eavey marked Plaintiff's Exhibit No. 1-C for identification; Sketch attached to deposition of Dr. Eavey marked Plaintiff's Exhibit No. 1-D for identification.)

MR. DOWDEY: At this time I would like to offer parts of Exhibit 1-A, which are the hospital records in this matter and which were identified on the deposition of Dr. Eavey, which has previously been admitted.

MR. DOWDEY: I offer part of Exhibit 1-A designated A-5 on the deposition, which is a pathological report.

84 THE COURT: What parts of the exhibit are you offering? Are you offering the entire record?

MR. DOWDEY: No, Your Honor. We have gone through and selected various parts. The part I am offering now is just that page numbered A-5, which is a pathology report.

THE COURT: Any objection?

MISS BACON: Yes, Your Honor. I object on the ground that it is not a competent document. The person who made and completed this report has not been called to testify and the accuracy of this report—

THE COURT: Just a moment. I know that you are familiar with the Federal Shopbook Rule.

MISS BACON: That is correct, and we submit that this does not fall within the Federal Shopbook Rule.

THE COURT: Very well. Why?

MISS BACON: Because it contains the examinations and opinions of an expert pathologist.

THE COURT: Very well, now I have your point.

MR. DOWDEY: And in that light I will agree to the elimination of the opinion at the end, Your Honor.

THE COURT: I think Miss Bacon's objection is well founded. The diagnosis of course is not admissible under the familiar case of New York Life Insurance v. Taylor.

How about the balance of this, Miss Bacon? Actually I should think you would want that diagnosis in because I thought the Government
85 claimed that there was an ectopic pregnancy. Then why do you object?

MISS BACON: That is the Government's contention, Your Honor. Our objection is to the admissibility of this particular document because—

THE COURT: But this is not a moot court proposition. If an exhibit doesn't harm you why do you object? This is a diagnosis that there is an ectopic pregnancy and that is what you, yourself, claim.

MR. DOWDEY: I withdraw that part of the exhibit that is a diagnosis, Your Honor. I only offer it as to the facts and not to that diagnosis.

THE COURT: What part are you offering?

MR. DOWDEY: Everything except the part at the bottom which says Diagnosis—Ectopic Pregnancy, and so forth.

THE COURT: Well, are you objecting to the balance of it?

MISS BACON: I am objecting to the balance of it, if Your Honor please. It does not fall within that category—

THE COURT: I don't think it does either, but I don't see any sense in your objecting because this seems to be favorable to your side. However, if you want to object I will sustain the objection.

MISS BACON: Your indulgence, please, Your Honor.

(Pause.)

86 MISS BACON: I persist in my objection, if Your Honor please.

THE COURT: Objection sustained. This is more than a routine entry, Mr. Dowdey.

That has been enlarged, the Taylor case has been enlarged somewhat to include a record of something that could be noticed by observation; but this is a report of a microscopic examination.

I will sustain the objection.

THE COURT: I want to say this, gentlemen, that I don't favor too many objections even when they are sound.

Now what is next?

MR. DOWDEY: I have indicated those that we are offering by clips * * *

87 THE COURT: Oh, yes. It is numbered Plaintiff's Exhibit A-25 as annexed to the deposition.

MISS BACON: Our objection is on the ground of relevancy, Your Honor. This relates to a subsequent operation, not related to this matter.

THE COURT: What is the date of the operation involved in this case?

MISS BACON: February 15.

THE COURT: And this is February 25th. On what theory is that admissible?

MR. DOWDEY: It is a subsequent admission. Immediately after this operation she was admitted for peritonitis at the site of the operation.
88

THE COURT: But what has that got to do with this case? It might bear on the question of damages, but not on the question of liability.

Your case is based upon the proposition that it was improper practice to remove the Fallopian tube. This is something that happened after the Fallopian tube was removed.

MR. DOWDEY: Well, it was part of the injury.

THE COURT: Objection sustained.

Now next is a document dated February 25, 1955. Do you want

to see this, Miss Bacon?

MISS BACON: The objection again is relevancy. It is a consent relating to the second operation.

THE COURT: Then it is obviously irrelevant. Objection sustained. I thought at first it related to the operation involved in this case.

89

(Portion of Plaintiff's Exhibit No. 1-A for identification received in evidence.)

THE COURT: Now next is a photostat of a handwritten document entitled Doctor's Progress Notes, dated March 25, 1955, Exhibit B-2. Any objection to that, Miss Bacon?

MISS BACON: There is objection, Your Honor. Dr. Eavey on deposition stated that he did not recognize and could not acknowledge that document.

THE COURT: In other words, it is not this doctor's notes?

MISS BACON: Yes.

THE COURT: What about that?

MR. DOWDEY: I never heard that before.

THE COURT: Of course if it was his handwriting, then it would be admissible as an admission against interest.

MR. DOWDEY: I am not aware of his having said anything about this document on deposition.

THE COURT: Well, the burden is on you to show that it was written 90 by him. Is there any evidence showing that it was written by him?

MR. DOWDEY: All of these documents came from the hospital, Your Honor.

THE COURT: That doesn't make them admissible. That merely makes them authentic and genuine, but it doesn't make them admissible.

MR. DOWDEY: Yes.

MISS BACON: Our further points of objection would be, Your Honor, that this relates to the second operation, having been made on March 25.

THE COURT: Then I am going to sustain the objection; first be-

cause the handwriting is not identified, second because it relates to another operation.

I think that exhausts the matters that you have clipped, Mr. Dowdey.

91

(Portion of Plaintiff's Exhibit No. 1-A for identification received in evidence.)

MR. DOWDEY: It's A-44, which is the operation report of February 15.

MISS BACON: There is no objection, and for Your Honor's convenience that note appears to have been read into the deposition on approximately page 56.

THE COURT: What page?

MISS BACON: If Your Honor please, I am checking my reference. It is approximately page 56.

THE COURT: Well, then I read this yesterday.

MR. DOWDEY: I may say that there is a variance between that testimony and the operative report.

92 THE COURT: What is the variance?

MR. DOWDEY: The variance is that in the operative report the physician fails to disclose the location of the pregnancy within the tube as being in the outer third of the tube, which is a very significant matter.

THE COURT: You say that is not in the oral testimony?

MR. DOWDEY: It is in the oral testimony, but not in the written report.

THE COURT: Very well. But otherwise the two are the same.

MR. DOWDEY: Essentially the same, I think.

THE COURT: Very well, in the absence of objection this is admitted.

Now is there anything further?

MR. DOWDEY: Yes, I think there are a few more there. I would

like to offer A-18 and A-22. Now these concern a subsequent admission. However, they are offered for a different purpose than previously.

THE COURT: What is the purpose?

MR. DOWDEY: These are offered to show that on the subsequent admission there was time for consultation, although the admission time between the time of admission and operation was only three hours.

MISS BACON: Objection on the ground—

93 THE COURT: Objection sustained. I want to say this: I think it makes no difference whether there was a consultation or not unless you can show that if there had been a consultation a different result would have been reached.

The question for me to decide is, as I see it, was it reasonably necessary for the doctor to have performed the operation that he did perform. Now whether he should have consulted somebody before he performed it I think is immaterial so far as the issue for me to decide is concerned unless you can show that if he had consulted everyone who was available for consultation they would have given the opposite advice.

MR. DOWDEY: I think his testimony is, if the Court please, that he admitted that his decision was in an area where specialists might disagree, and therefore I think the question is relevant.

THE COURT: No, I am going to hold that it does not make any difference unless the other doctors who might have been consulted would testify that they would have given different advice.

Now there is another thing here. I don't think you accurately state the testimony of the doctor on deposition, as I understand it. He didn't testify that in this particular case it was a matter that different doctors would have reached different conclusions. What he did testify
94 to was that this general subject is a matter of judgment and opinion, which is entirely different. Also he did not testify, as I understood you to say, that there was a choice here and that he made this particular choice. He testified that in those cases in which the pregnancy is very early and very small it is possible to shell out the pregnancy. He didn't testify that there was a choice in this particular case

MR. DOWDEY: He testified, if the Court please, however, that this

was as early as they're ever discovered and that the pregnancy was so small that it could not be discovered on the—

THE COURT: He did not testify that in this case there was a choice, as you stated. I expect counsel, when they state what is in the record, to be one hundred per cent accurate.

Very well, now you may proceed.

MR. DOWDEY: I think that covers it, Your Honor, as far as these exhibits are concerned.

THE COURT: Very well.

MR. DOWDEY: I offer Exhibit 1-C and 1-D, which are the drawings made by the Doctor.

THE COURT: You mean those large drawings on the blackboard?

MR. DOWDEY: No, they are the drawings attached to the deposition. These are merely enlargements of them.

THE COURT: Let them be admitted. I take it there is no objection.

MISS BACON: No objection, Your Honor.

MR. DOWDEY: I would like at this time to offer parts of the deposition of ***** Dr. William D. Johnson.

Beginning at page 2.

THE COURT: How far down?

MR. DOWDEY: Page 3 down to the answer "Yes," about two-thirds down.

THE COURT: Yes, I see.

Then what is next?

MR. DOWDEY: Page 4.

THE COURT: Starting where?

MR. DOWDEY: At the bottom of the page beginning with the question "At the time you saw Mrs. Harvey where was she?"

Would the Court prefer that we mark a copy?

THE COURT: I am marking my copy, I am marking the original, so it will be clear what is going in.

Now how far over?

MR. DOWDEY: Down to page 5 where we went off the record.

THE COURT: Yes.

MR. DOWDEY: Page 6 beginning with the examination by Miss Bacon, near the top of the page where it says "By Miss Bacon," after that.

THE COURT: Where does page 5 end? Oh, yes, that ends just about the middle of the page. I see.

MR. DOWDEY: Yes.

THE COURT: How far does this go, Mr. Dowdey?

MR. DOWDEY: Down to 7, on page 7 where it begins "Did you inquire of Mrs. Harvey," down to there but not including that question.

THE COURT: Miss Bacon, as soon as Mr. Dowdey is through offering the portions of the deposition that he desires to offer you have immediately the right to offer any other portions of the deposition, just as though the witness were on the witness stand and you were cross examining.

97 What is next?

MR. DOWDEY: Beginning at the top of page 8.

THE COURT: Well, you don't want the questions and answers where he says "I don't recall," do you?

MR. DOWDEY: No; the question beginning at the top of page 8, "Did you have any discussion."

THE COURT: He says "I don't recall." You can have it in the record if you want to, but I don't know why you should want it.

MR. DOWDEY: Well, it is important.

THE COURT: Very well.

MR. DOWDEY: It is important because—

THE COURT: Very well, we won't talk about it.

How far does this go?

MR. DOWDEY: To the answer on the top of page 9.

MISS BACON: I object to the last portion of the answer to the question on page 9 which states, "I am sure that is what he had in mind when he scheduled it that way."

THE COURT: What is the objection to that?

MISS BACON: My objection is on the ground that it is not competent to testify what is in the mind of the other person.

THE COURT: I don't think it is competent either, but what is the reason for objecting to it?

98 MISS BACON: Incompetent testimony.

THE COURT: Objection overruled. Don't object to things that are incompetent if they don't hurt you. As a matter of fact, I think this helps the Government.

Now what is next?

MR. DOWDEY: And beginning at page 10 where the examination is begun by Miss Bacon "What function, if any."

THE COURT: Just below the middle of the page, is that it?

MR. DOWDEY: Yes.

THE COURT: How far does that go?

MR. DOWDEY: Continuing through page 11 down to page 11, the remark that was paragraphed in the answer, "But making rounds if I am first on the scene," I move to strike that and I do not offer it.

THE COURT: You can't move to strike it. You don't have to offer it.

MR. DOWDEY: I didn't offer it. I don't offer that. But the testimony down to that.

THE COURT: Very well.

MR. DOWDEY: Then picking that up again, on page 11, "Do you recall whether Mrs. Harvey initiated with you any conversation?"

99 THE COURT: Very well. How far over does that go?

MR. DOWDEY: To page 12 down to the answer "I don't recall," about in the middle of the page.

THE COURT: Anything further?

MR. DOWDEY: No, Your Honor.

Beginning on page 13 with my cross-examination.

THE COURT: How far over?

MR. DOWDEY: Page 18.

THE COURT: Now whereabouts on page 18 does this stop?

MR. DOWDEY: It stops after the answer "Since I went in practice in 1959."

THE COURT: Very well.

MR. DOWDEY: And it resumes—Did you have something, Miss Bacon?

THE COURT: Did you have any objections?

MISS BACON: Your indulgence one moment, please, Your Honor.

I am prepared to proceed, Your Honor. I have no objections.

THE COURT: Very well.

MR. DOWDEY: Resuming at page 18, my examination, "Was there a consultation."

100 THE COURT: Yes, I see it. How far does this go?

MR. DOWDEY: Down to page 20 where there is an objection by Miss Bacon in the middle of the page.

THE COURT: Very well.

MR. DOWDEY: Resuming on page 21, in the middle of the page where it says, "Mr. Dowdey: Well, now, I think my last question."

THE COURT: How far over does it go?

MR. DOWDEY: Over to 24, to the top of the page, where it says, "I had no independent recollection."

THE COURT: Very well. What is next?

MR. DOWDEY: Resuming at page 25, at the bottom of the page where it says "To get back to the consultations."

THE COURT: And how far over?

MR. DOWDEY: To the conclusion.

THE COURT: Very well.

MR. DOWDEY: There are objections in there and colloquy about the objections.

THE COURT: You intend that those be omitted?

MR. DOWDEY: Yes.

THE COURT: Very well.

MISS BACON: I have objection beginning on page 26, at the bottom of the page, "The record will show I am referring to the Standard for

Hospital Accreditation." This document has been ruled inadmissible in
101 in this case and the questions with respect to it are therefore inadmissible.

THE COURT: I understand, but this was cross examination. No, I am going to allow these questions and answers.

MISS BACON: If Your Honor please, on direct examination this document was not referred to.

THE COURT: I am going to allow these questions and answers. In a civil case any doubt as to admissibility of evidence should be ruled in favor of admissibility. That is the usual practice of the courts. This isn't going to hurt you, it is not going to prejudice you.

Anything else?

MISS BACON: I have no other objections, Your Honor.

THE COURT: Very well. A great deal of this is argumentative material and probably if the witness was on the witness stand I would have stopped it so as not to permit unnecessary consumption of time, but it is here, it might as well go in.

Now, Miss Bacon, are there any other portions of this deposition that have not been read by plaintiff that you would like to read? If you would like to take a few minutes to go through this we will take our usual mid-morning recess at this time. We generally take it around
102 11:15, we might as well take it now, and you will have a few minutes to go through this to take an inventory, to see if there is any part of this deposition that you want to read.

MISS BACON: Thank you.

(Brief recess.)

THE COURT: You may proceed.

MISS BACON: By cross-examination, I would call Your Honor's attention to page 7 of Dr. William Johnson's deposition beginning with the question where Mr. Dowdey terminated his reference. The question is, "Did you inquire of Mrs. Harvey whether"—

MISS BACON: From that point to the bottom of the page.

THE COURT: Very well.

MISS BACON: That is the only addition which I have.

MR. DOWDEY: May I state this, Your Honor. I have this observation to make—

THE COURT: This is no time to make observations. You make that in your final argument.

MR. DOWDEY: There is a technical objection to these.

103 THE COURT: Do you object or don't you?

MR. DOWDEY: Yes, I object.

THE COURT: On what ground?

MR. DOWDEY: Because he is not answering—the answer he gives is a matter of policy, according to his own statement.

THE COURT: I am going to overrule the objection. That goes to the probative weight of the answer.

MR. DOWDEY: And I might say, with respect to the other testimony, which has been offered, that because this is a non-jury case we have not made objections of this kind.

(Listing of accredited hospitals
marked Plaintiff's Exhibits No. 4
for identification.)

(Listing of accredited hospitals
marked Plaintiff's Exhibit No. 5
for identification.)

104 MR. DOWDEY: I offer Plaintiff's Exhibits 4 and 5.

THE COURT: What are they?

MR. DOWDEY: Which are the listing of accredited hospitals by the Joint Commission on Accreditation, showing those listed in the District of Columbia, Maryland and the surrounding area which have met the standards of the Joint Commission as of December 31, 1953 and as of—

THE COURT: You don't have to give the details, just to identify the document.

MISS BACON: I have objection.

THE COURT: I am going to sustain the objection. I think accreditation of hospitals has nothing to do with this case.

MR. DOWDEY: If I may pursue the matter, the accreditation

establishes that these standards have been met by virtue of the language of this exhibit.

THE COURT: What has that got to do with the case?

MR. DOWDEY: It connects up the previous exhibits and also the discussion of Dr. Johnson in his deposition about the standards.

THE COURT: No, the fact that certain hospitals or a majority of them meet certain standards does not prove what the usual practice was in the District of Columbia. It is not competent evidence. I will adhere to my ruling.

105 MR. DOWDEY: May I make one other observation?

THE COURT: Is that directed to both Exhibits 4 and 5?

MR. DOWDEY: Yes, Your Honor. They are for different periods of time.

THE COURT: Yes, I will hear you.

MR. DOWDEY: With respect to Exhibits 2 and 3 previously offered and which were not received, I would like to make my proffer more specific, only of certain paragraphs, if the Court please.

THE COURT: Very well.

MR. DOWDEY: Exhibit 2 for identification, I would like to offer the third paragraph on page 3, the third paragraph from the top and the fourth paragraph, which is headed in big, bold caps "Required."

THE COURT: I will adhere to my ruling excluding the evidence.

MR. DOWDEY: I would like to offer—

THE COURT: You have offered the whole document.

MR. DOWDEY: But the whole document is not relevant, I concede that.

THE COURT: I can't see how the description of a physical plant is relevant to this case either.

MR. DOWDEY: If the Court will let me have the exhibit back.

106 THE COURT: Yes, surely. What particular clause or paragraph or sentence do you consider as having a bearing on this case, Mr. Dowdey?

MR. DOWDEY: I also offer in Exhibit 2 the first paragraph on page 7 titled "Consultations," which is listed under the heading "Required."

THE COURT: I am going to adhere to my ruling that this is not

the proper method of proof; also on the ground that the question of consultation, as I see it, is not relevant to the issues of this case unless it is shown that a consultation would have resulted in advice to do something else than what was done.

MR. DOWDEY: May I say this, Your Honor: it cannot be shown that consultation would have necessarily produced a different result. However, the physician has indicated that this was an area in which specialists would differ.

THE COURT: I am not going to hear any more argument on this point. You have to show that what the doctor did was wrong, and if he had consulted ten people and they all agreed with him and if it was wrong it would still be wrong. On the other hand, if he consulted ten people and they disagreed with him and it was right it still would be right.

MR. DOWDEY: May I make this further observation, if the Court
107 please, with respect to my proffer of several pieces of evidence here. I would like to call the Court's attention to the language in the Court of Appeals in several cases about this problem of proof in mal-practice cases and I am directing your attention specifically to Goodwin against Hertsberg, 91 U.S. App. D.C. 385.

THE COURT: Any ruling of the Court of Appeals is binding on me, any dicta are not.

There are times when it is very difficult to prove mal-practice, yes. I think perhaps it should be difficult, for the doctors' protection, because there are many unfounded claims. But, on the other hand, there are cases of mal-practice that are not difficult to prove. I had a mal-practice case that I tried without a jury last spring where I found for the plaintiff. There was no difficulty of proof.

I think a good deal of that supposed difficulty is speculative. There is a thought that doctors won't testify against each other. Well, they don't like to testify against each other, neither do lawyers, neither do members of any group. It is not peculiar to doctors.

MR. DOWDEY: Well, if the Court please—

THE COURT: But I think if it contrary to proper practice under

the circumstances of this case to have performed an operation or the operation that was performed—when I say proper practice, accepted
108 practice in this locality at the time—I shouldn't think you would have much difficulty getting some specialist to say so.

MR. DOWDEY: May I direct your attention, if the Court please, to this specific language. It is very short. The language is, as Your Honor has remarked:

"Mal-practice is hard to prove. The physician has all the advantage of position. What therefore might be slight evidence when there is no such advantage as in ordinary negligence cases takes on greater weight in mal-practice suits."

THE COURT: What are you reading from?

MR. DOWDEY: That is from the case of Goodwin against Hertsbert, 91 U.S. App. D.C. 385.

THE COURT: And who said this?

MR. DOWDEY: This is the opinion of the Court.

THE COURT: I know. Who said it, what Judge?

MR. DOWDEY: I'm sorry, I can't tell you that.

THE COURT: Anyway, I don't know what point was decided in that case. I have observed that too many lawyers will quote from a case without showing what point was decided in that case. A case is only an authority for the point that was decided and general discussion and remarks of the Judge are of no more effect than a law review article
109 would be written by the same person.

MR. DOWDEY: Well, that may be, but a law review article would be persuasive, I trust.

THE COURT: It might be and might not be.

Now let's move ahead. I have ruled on this and it is not my practice generally to hear argument after I make a ruling and generally not to hear arguments on questions of evidence, anyway.

I realize you have a difficult case and it is a difficult case to prove because of the nature of your case, not because it involves a doctor. You have got to prove that what the doctor did was wrong, and while I was very much impressed by your opening statement, as the evidence developed my mind began to be filled with doubts.

I realize too that this is in one sense a very serious matter, to repeat what I said yesterday, it has emotional overtones, and that is one of the reasons why I don't want to deal with the matter summarily. But, nevertheless, there are two things involved here. It isn't just a question of money. In all these cases involving physicians when they are sued for negligence professional reputation is at stake as well as the question whether somebody should pay some money to somebody else.

MR. DOWDEY: And I would like to say, Your Honor --

110 THE COURT: No, I don't invite answers to my comments. You proceed, Mr. Dowdey.

(Mt. Sinai Hospital records marked Plaintiff's Exhibit No. 6 for identification.)

MR. DOWDEY: Exhibit 6, which I offer, are the records of Mt. Sinai Hospital in Miami, and I would like to offer selected parts, abbreviated parts of this record.

THE COURT: What period do they cover?

MR. DOWDEY: They cover the patient's previous ectopic pregnancy experience in November of 1953.

THE COURT: How is that relevant to this case?

MR. DOWDEY: It is relevant, one, in showing the usual procedure in treating, but more important I think it shows her --

THE COURT: You have to show the usual procedure in the metropolitan area of Washington, not in Miami. Moreover, the fact what was done in one particular case is not proof of usual procedure.

MR. DOWDEY: You are quite correct. The point, however, is that
111 Mrs. Harvey's understanding of what ectopic pregnancy involved was conditioned by her experience in this hospital.

THE COURT: Is there objection?

MISS BACON: Yes, there is objection.

THE COURT: Objection sustained. I think that is entirely outside the issues.

MR. DOWDEY: In such case, then, I will not -- well, I better make

my proffer, nevertheless.

THE COURT: Well, you have made your proffer. You can have the exhibit marked for identification. That would indicate what you have offered. You already have had it marked, have you not?

MR. DOWDEY: Yes, Your Honor.

THE COURT: Very well.

MR. DOWDEY: Mark this.

THE DEPUTY CLERK: Plaintiff's Exhibit No. 7.

MISS BACON: No objection.

MR. DOWDEY: I offer Plaintiff's Exhibit No. 7, which is a letter of Dr. Wilson, a letter to the U. S. Attorney from a Dr. J. C. Wilson.

THE COURT: Very well, let it be admitted.

(Letter from Dr. J. C. Wilson to U.S. Attorney marked Plaintiff's Exhibit No. 7 and received in evidence.)

(Documents from Dr. Frederick Braden to U. S. Attorney marked Plaintiff's Exhibit No. 8 for identification.)

MR. DOWDEY: Yes, Your Honor. I offer Plaintiff's Exhibit 8, which is a collection of documents received from Dr. Frederick Braden in Pensacola, Florida, addressed to the United States Attorney, pursuant to the pretrial order in this case, and I offer pages 1, 3, 4, 7, 8, 9, 10, 11 and 12.

MISS BACON: I have objection, Your Honor, on the grounds that these are not relevant. They relate to a 1958 hospitalization in Florida, and further, that they do not come within the Federal Shopbook Rule, containing various expressions of opinion and are not --

THE COURT: They don't come within what?

MISS BACON: The Federal Shopbook Rule.

THE COURT: No, of course they don't come within that. Counsel said something about the pretrial order. Was there any stipulation concerning them in the pretrial order?

MR. DOWDEY: Yes, Your Honor.

MISS BACON: There was, Your Honor. It was a stipulation subject
113 to all legal objections.

THE COURT: I want to see what the stipulation is.

The one objection that impresses me is that this relates to another hospitalization. What about that?

MR. DOWDEY: It is in 1958 and, if the Court please, this was the time in which, as a necessary consequence of the 1955 operation, it was discovered that there had been only a partial removal of the tube, and this is shown by that.

THE COURT: How does that bear on this case?

MR. DOWDEY: Well, the matter of discovery of the --

THE COURT: Specifically how does it bear on this case?

MR. DOWDEY: On the question of delay in filing suit, Your Honor. There were a series of events which excited inquiry and this was --

THE COURT: Discovery of what? You have got to be precise. Pinpoint your thought a little bit.

MR. DOWDEY: Discovery of the wrong committed. She had no knowledge of this.

THE COURT: No knowledge of what?

MR. DOWDEY: She had no knowledge of the several acts of negligence that we have alleged.

THE COURT: Specifically what did she have no knowledge of?

114 MR. DOWDEY: She had no knowledge that there had been any choice at all in this matter.

THE COURT: There is no proof that there was any choice so far.

MR. DOWDEY: Well, if the Court please, I respectfully suggest that --

THE COURT: No, I am going to sustain the Government's objection to this. This may be admissible on the issue of damages if I hold that there is liability, because if an erroneous operation requires subsequent treatment that otherwise would not have been required, I think that would be admissible on the issue of damages, but it is not admissible on the issue of liability. I am excluding it only as to the issues of liability.

I want to say this: that even if she did not know there had been a

choice and there was a choice, that that fact would not toll the statute. The statute might be tolled, for example, if the fact that the operation was performed was not known and was discovered later. That would be different. But merely that she did not realize she had a cause of action does not mean that the statute is being tolled.

Now you may proceed. Anything further?

MR. DOWDEY: Yes, Your Honor.

115 MR. DOWDEY: I would like to make a separate proffer of page 7.

THE COURT: Very well, let me see it.

MR. DOWDEY: In Exhibit 8, because this is a statement of Dr. Wilson and his statement has already been received into evidence and I think this may pinpoint the time a little better. It says about a year ago. You will notice in the letter to the U. S. Attorney he indicates it was in 1955-'56, whereas this would place it in 1957.

THE COURT: Any objection?

MISS BACON: Objection, Your Honor.

THE COURT: Let it be admitted.

(Page 7 of Plaintiff's Exhibit 8 for identification was received in evidence.)

(Letter from Dr. Vaughan to U. S. Attorney marked Plaintiff's Exhibit No. 9 for identification.)

116 MR. DOWDEY: . . . I offer Plaintiff's Exhibit No. 9, which also was obtained by the United States Attorney pursuant to the pretrial order.

THE COURT: Obtained pursuant to the pretrial order? Just what do you mean?

MR. DOWDEY: There was a stipulation in the pretrial order that in return for my authorizing them to obtain this information, that the information would be admissible without formal proof.

THE COURT: Just let me see. Will you direct my attention to the

exact stipulation, because the phraseology of those stipulations is quite important.

What is your objection? This seems to relate to a later hospitalization.

MISS BACON: That is the nature of my objection, Your Honor.

THE COURT: Very well. Assume that formal proof is waived, I still think this is irrelevant because it relates to a subsequent hospitalization, Mr. Dowdey.

MR. DOWDEY: I think it merely shows her course subsequent to this operation.

THE COURT: Suppose it does. Surely it does. Now how is that
117 relevant? It may satisfy our curiosity, but how is it relevant to the issues of this case so far as liability is concerned? If there is liability it may be relevant on the issue of damages.

I am going to sustain the objection.

MR. DOWDEY: I would like at this time to make an additional proffer with respect to Exhibit 1-B.

THE COURT: What is 1-B?

MR. DOWDEY: 1-B were the hospital medical reports of the United States.

THE COURT: Yes, you may do so.

MR. DOWDEY: I do not offer them with respect to the diagnosis, but only to show that Mrs. Harvey was being treated by the Air Force rather continuously through 1957.

THE COURT: You haven't told me what you want to offer.

MR. DOWDEY: It would be the balance -- that would be all of Exhibit 1-B, but only to the extent of the dates and names shown thereon.

THE COURT: All of 1-B?

MR. DOWDEY: All of 1-B, but only those parts that show her name and the date that she was treated.

THE COURT: Well, I suppose that is innocuous. You have got to state what pages you are offering.

118 MR. DOWDEY: What pages?

THE COURT: Yes.

MR. DOWDEY: B-1, -2, -3, -5, -6, -7, -8 --

THE COURT: All you are taking from those pages are dates, is that it?

MR. DOWDEY: Dates and showing that she was treated.

THE COURT: What has that got to do with this case?

MR. DOWDEY: It does have to do with these cases where there is delay because she was still under the care of Air Force medical personnel up through 1957.

THE COURT: I don't understand that you can toll the statute of an action for mal-practice by continuing to use the defendant doctor.

MR. DOWDEY: Their failure to disclose is a continuing failure, and some of the cases have made this distinction, Your Honor.

THE COURT: Failure to disclose what? There hasn't been any proof of any failure to disclose anything here.

MR. DOWDEY: Failure to disclose that there was an alternative and failure to advise her of the possibility of tubal repair.

THE COURT: There is no proof that such a thing was possible or that there was an alternative course. I am going to exclude this as irrelevant to any of the issues in this case.

MR. DOWDEY: May I continue with my proffer?

THE COURT: You may proceed.

MR. DOWDEY: B-9, B-10, B-11, B-12 and B-13.

THE COURT: It is the same sort of thing?

MR. DOWDEY: Yes, it is the same thing. B-14. That is it.

THE COURT: Suppose you are tendering the whole record and I am excluding it all except anything that has already been admitted so far. I think records of other hospitalizations or of medical treatment on other occasions have no bearing upon the issue of liability in this case. They may be relevant on the issue of damages if that issue should remain in the case.

MR. DOWDEY: I am not offering the whole record, I am just offering those things that I identified and for the limited purpose and for the limited part.

(A.M.A. Principles of Medical Ethics marked Plaintiff's Exhibit No. 10 for identification.)

MR. DOWDEY: I offer Plaintiff's Exhibit No. 10 for identification, which is a certified copy of certain portions of the Principles of Medical Ethics published by the American Medical Association. I offer Article 3, Sections 1, 2 and 7.

MISS BACON: I have objection, Your Honor, on the ground that they are not competent evidence relevant to the issues of this case.

THE COURT: I agree with you thoroughly, but I am going to overrule the objection. He might as well offer the Ten Commandments. I will admit it.

(Plaintiff's Exhibit No. 10 for identification was received in evidence.)

THE COURT: Just like I suppose if a lawyer was being sued for negligence he wouldn't want to object to the admissibility of the American Bar Association Code of Ethics even though it is not competent.

121

GEORGIANA R. HARVEY

Plaintiff, called to the witness stand, having been duly sworn, was examined and testified as follows:

THE COURT: Mr. Dowdey, before you commence may I remind you that at this stage of the case any matter that goes to the issue of damages should be withheld because if liability is established, then you can recall the witness a second time for testimony on damages. Consequently, evidence of subsequent hospitalizations would not be relevant at this time.

MR. DOWDEY: It may be relevant not in connection with damages but also in connection with --

THE COURT: If it is relevant on the issue of liability, yes; but bear in mind we are now limiting the evidence to the issue of liability.

DIRECT EXAMINATION

BY MR. DOWDEY:

Q. Will you state your name, please? A. Georgiana Russel
122 Harvey.

Q. And are you the plaintiff in this action? A. Yes, sir.

Q. Now directing your attention to February 15, 1955, were you

married at that time? A. Yes, I was.

Q. And to whom? A. To Lieutenant Colonel Julian A. Harvey, United States Air Force.

Q. And did you on that date have occasion to go to a military hospital? A. Yes, I did.

Q. When and where? A. It was fairly early in the day and I went to Bolling Air Force Base Hospital.

Q. Had you ever been to a military hospital before? A. No.

Q. Had you ever been treated by armed services personnel, medical personnel? A. No.

123 Q. Do you know what time of the day you arrived there? A. Not exactly.

Q. Approximately? A. Before noon, I believe, but I don't remember.

Q. Now will you tell us what happened there? A. I went to the, I believe they call it the out-patient clinic, to ask to see a doctor and after waiting a while I saw Dr. Eavey. I explained to him that I had reason to believe something was wrong and gave him the general description of my complaint. And he suggested that I should be examined and he examined me and told me I should stay there, that he didn't know what was the matter but he was going to find out and that he would like to do an exploratory examination under anesthetic.

Q. What precisely was your complaint when you entered this hospital? A. I had some very small show of blood at the wrong time.

Q. And did you have some pain in connection with that? A. Not any particular pain, no; mild discomfort.

Q. Was there any discussion, when you first saw Dr. Eavey in the out-patient clinic, of an ectopic pregnancy? A. I told him that I had had one previously and that was during the time he was examining me.

124 And he merely said that an ectopic pregnancy was the most difficult thing that there was to diagnose and that he would have to look and see what the matter was. But he didn't tell me I had one.

(At 12:30 p.m. trial stood in recess, to reconvene 1:45 p.m.)

THE COURT: You may proceed, Mr. Dowdey.

BY MR. DOWDEY:

Q. I think you had just reached the point where Dr. Eavey said that he was going to perform an operation, an exploratory operation. Would you tell us what happened then? A. After he said he was going to perform --

THE COURT: You will have to talk so we can all hear you; otherwise it won't be of any help to you. You can come closer to the microphone if you wish. That is what it is there for.

A. You mean after he told me he was going to perform the ex-
125 ploratory operation?

Q. Yes. A. He gave some instructions to this person out at the desk. There was a receptionist there and she gave me many, many pieces of paper and I was told to go to various places to have -- there was one trip to a laboratory to have some blood work done and various things that have to be done before surgery. And I spent quite a lot of time just running around getting these errands done.

Q. Walking through the corridors or the hospital? A. Yes. And each place I would go I would show them the other pieces of paper I had and they would tell me where to go next.

Q. Now did there come a time when you arrived at a hospital ward or a hospital room? A. Yes, yes.

Q. And did you have any conversations with any person there, with any member of the medical staff there? A. No, other than the nurse that showed me, you know, where my bed was.

Q. Did you talk to any physician there? A. Someone came and took some information about where I was born and how old I was and again normal -- asked me if I was allergic to any drugs.

126 Q. Now at any time did you sign a consent to an operation? A. Not to my knowledge.

Q. You don't recall signing? A. I don't recall, no.

Q. When did you next see a physician? A. In the operating room.

Q. And what physician was that? A. Dr. Eavey.

Q. And did you have any conversation with him there? A. No.

Q. Were you placed under an anesthetic? A. Yes, in the operating room.

Q. And what is the next thing that you recall? A. I woke up in bed and I had no incision in my abdomen and so I assumed that nothing had been done. And I asked a nurse and she didn't know, or, rather, she said the doctor would tell me. And later on he came in.

Q. When you say you noticed you had no incision, how did that have significance for you?

THE COURT: She just said she thought that nothing had been done.

BY MR. DOWDEY:

Q. Had you had a previous experience with an ectopic pregnancy?

127 A. Yes, sir.

Q. And when and where was that? A. That was in Florida in 1952.

Q. It was within -- A. It may have been 1953.

Q. It was within a couple of years of this time? A. Yes, it was.

Q. And had there been an incision in that case? A. Oh, yes.

Q. And was your -- describe your condition, just very briefly, on that previous occasion.

THE COURT: I don't think we will go into the previous occasion.

MR. DOWDEY: I might suggest, if the Court please, that inasmuch as that would go to the materiality of this testimony and since, as Your Honor has previously indicated, that question may not be resolved until we finally pass on the legal questions involved in this case, I would ask leave to include this testimony pursuant to Rule 41 --

THE COURT: I will let you make a proffer. What do you expect the testimony to be?

MR. DOWDEY: And I would like to have that testimony recorded.

128 THE COURT: No, I shall not take it, but I will let you make a proffer, an offer of proof. What answer do you expect the witness to give?

MR. DOWDEY: The experience that she had --

THE COURT: What answer do you expect her to give?

MR. DOWDEY: The answer I expect her to give is that the experi-

ence she had in Florida had been in an acute emergency situation where she was unconscious, where there was extensive bleeding, where there had been an abdominal incision, and that she had been treated throughout as an acute emergency, and that her life was very obviously in peril at that time, and that she understood that an ectopic pregnancy involved this kind of critical life and death situation.

THE COURT: I am going to adhere to my ruling excluding it.

MR. DOWDEY: And I would like to include her testimony pursuant-

THE COURT: You have made your offer of proof and that is enough.

MR. DOWDEY: My request is made pursuant to Rule --

THE COURT: No, I am not going to hear any more of that. Go
129 ahead with your examination.

MR. DOWDEY: If Your Honor will allow me to make this proffer pursuant to the rule I will not take up the Court's time.

THE COURT: No; I know the rules as well as you do.

MR. DOWDEY: Perhaps a lot better. I don't concede that --

THE COURT: I will not hear any more on this. Proceed with your examination.

BY MR. DOWDEY:

Q. When did you next see a physician after you regained consciousness? A. Dr. Eavey came into my room. I don't remember exactly how long after I regained consciousness, but before too long.

Q. And did you have a conversation with him at that time? A. Yes

Q. And what was that conversation? A. I asked him whether he had done anything to me.

Q. And what did he say? A. And he said yes, that he had removed the Fallopian tube.

Q. And had you previously had another Fallopian tube removed?
130 A. Yes, sir.

THE COURT: We have had that once before or we had it twice before. We had it before noon and we had it a few minutes ago.

MR. DOWDEY: This goes to the fact that a -- a different point, Your Honor.

THE COURT: It may go to a different point, but there is no use repeating the same fact three times. The question is excluded as repetitious. Let's move along.

MR. DOWDEY: If the Court will indulge me a moment, I am not sure that this record shows that she had the Fallopian tube removed previously, and that is all I would like to establish.

THE COURT: Well, will it be conceded that she had the other Fallopian tube removed previously?

MR. HANNON: May I have your indulgence just a moment, Your Honor?

(Pause.)

THE COURT: I am very much annoyed when the same question is asked two or three times and you must not do that.

MISS BACON: It is conceded that her other Fallopian tube had been removed.

THE COURT: Very well. You know, I want to give every case as
131 much time as is reasonably necessary, but after all, we have a great many cases and if I take too long with one case other cases are being backed up and other litigants and lawyers are entitled to have their cases heard. Now I want you to take all the time that is necessary, but I want you to move with a reasonable degree of expedition and not to repeat things.

MR. DOWDEY: May I have the last question and answer read?

THE COURT: Yes.

(The last question and answer were read by the Reporter.)

Q. Did he say anything more? A. I was upset because I didn't know that he was going to do this. I thought that --

THE COURT: Just a moment. I don't think you caught the question

(The last question was read by the Reporter.)

A. He said something in response to something that I said to him then.

Q. And what was that? A. I told him that I was upset because I did not know he was going to do this, and he told me that it was done.
132 And I asked him if this meant that I could never have children and he said that is what it meant.

Q. Well, you knew before the operation, did you not, that if an ectopic pregnancy were discovered he would remove the tube? Did you not know that? A. Well, of course I am not a doctor, but I assumed that there would be an operation involved, but I didn't know that it was going to be such a final thing.

Q. Did he offer any further explanation of why he had proceeded?

A. No.

Q. Did you at any time ask him whether it was necessary to have done so at this time or any time later while you were in the hospital?

A. It was pretty near the same time. Yes, I asked him if there wasn't anything that could have been done and he said no.

Q. Did you ask him if anything could be done afterwards to remedy this situation so that you might bear children? A. Only to the extent that I asked him if I could ever become pregnant, and he said if I do, please let me know. In a joking way he said that.

Q. Now subsequently did you find out that he had not removed the entire tube? A. Yes, sir.

133 Q. When was that? A. It was after an operation, a complete hysterectomy in 1958. It was after that.

THE COURT: You had a hysterectomy in 1958, is that it?

THE WITNESS: Yes, sir.

BY MR. DOWDEY:

Q. After you left the hospital -- strike that.

Were you subsequently admitted to Bolling Air Force Base Hospital after this first admission of February 15? A. Yes, sir.

Q. And when was that? A. It was about ten days after the first operation.

Q. And were you again treated by Dr. Eavey? A. Yes.

Q. What was your condition on admission? A. You mean to my own personal knowledge?

Q. Yes. A. I didn't know, but I was in excruciating pain, very, very sick, and I was rushed into emergency surgery.

Q. And abdominal surgery was performed on you? A. Yes, sir.

Q. Did you have occasion to be treated by Air Force physicians

134 after that second admission to Bolling Air Force Base Hospital?

THE COURT: How is that relevant?

MR. DOWDEY: Just to establish the continuity of the treatment by them. I am not going to go into the details.

THE COURT: But how is that relevant? You are telling me what you want to establish, but how is that relevant?

MR. DOWDEY: Because they had a continuing duty to inform her with respect to her health.

THE COURT: Did you wish to address the Court, Miss Bacon?

MISS BACON: I was rising to object on the grounds of relevancy.

THE COURT: Objection sustained.

BY MR. DOWDEY:

Q. Were you ever told by Dr. Eavey or by any medical officer of the Air Force that there had been an alternative to removing your tube in February of 1955?

MISS BACON: An objection. There is no evidence of there being an alternative in this case.

THE COURT: I understand, but that is one way of proving it. I think the question is admissible. Suppose the answer is yes? I can't exclude it.

135 THE WITNESS: Not by -- I was not told that by any Air Force doctor.

BY MR. DOWDEY:

Q. Were you ever told anything by an Air Force doctor that would indicate that the tube might have been repaired after it had been removed?

THE COURT: I am not going to permit that kind of question, anything to indicate. I think you better reframe the form of the question.

Q. Were you ever told by an Air Force physician after the operation of February 15, 1955, that the tube might still be repaired in any way? A. No.

Q. You were never told that? A. No, sir.

THE COURT: Of course you are assuming a fact. This is really a leading question. However, we will pass that.

MR. DOWDEY: I have no further questions.

THE COURT: Try not to lead your witness.

MR. DOWDEY: I have no further questions.

THE COURT: Miss Bacon.

CROSS-EXAMINATION

BY MISS BACON:

Q. Mrs. Harvey, you are presently married to someone else, are
136 you not? A. Yes, ma'am, I am.

Q. And this is your fourth marriage, is that correct? A. No,
ma'am, it is not.

Q. You were married to Mr. Wesley Humont, is that correct? A.
That is correct.

Q. And then you were twice married to Mr. Harvey, is that cor-
rect? A. Well, yes. I thought you meant four different people.

Q. To three different people, is that correct? A. Yes, ma'am.

Q. And during the course of those marriages have you ever given
birth to a child? A. I have not.

Q. Have you experienced miscarriages in the course of those mar-
riages? A. Only what is on record as -- yes, I was told I was preg-
nant after I had no Fallopian tubes. That is on record.

Q. Did you ever have a condition while you were married to Mr.
Humont which was described to you as a miscarriage? A. Not that I
137 recall.

Q. Am I correct in understanding, Mrs. Harvey, that Dr. Eavey
did not tell you that you had an ectopic pregnancy prior to the time you
went into the operating room? A. That is correct. He told me he
didn't know what was the matter with me.

Q. Did you have a discussion with him concerning the possibility
of this being an ectopic pregnancy? A. Yes, he said that was a pos-
sibility.

Q. So that prior to going into the operating room you knew it was
possible that you had another ectopic pregnancy? A. I'm sorry, but I
just didn't know.

Q. Do you recall giving your testimony on deposition, Mrs. Harvey,
on November 9, 1962 and being asked the question on page 10: "What
did he tell you?"

And responding: "He told me that he wanted to examine me."

And being further asked: "What else did he tell you? Answer: He told me that he felt sure that I had an ectopic pregnancy because I had one before." A. Yes, ma'am, I realize that. I remember that testimony.

138 Q. And do you similarly recall your testimony on that same time, November 9, 1962, at page 14, do you recall the question: "Did you discuss how long you were going to be in the hospital?"

And giving the answer: "I don't think so, no."

Then the question: "Did you ask?"

And the answer: "No. I don't think so. Because -- sometime during the course of this examination or something, when he had already said to me that he felt sure that I had an ectopic pregnancy -- his whole conversation was that -- well, we will just have to look and find out. That's all. I wasn't in a position to ask any questions particularly other than knowing -- I knew what he was going to do."

Do you recall those questions and those answers? A. Yes, ma'am, I recall them quite clearly.

Q. Are they true? A. Yes, everything I have said is true.

Q. Showing you exhibit which has been marked as Plaintiff's 1-A-15 I ask you if that is your signature halfway down the page on this
139 document? A. It looks like it is, but I can't tell. It does look like it, though. I don't remember.

THE COURT: Was this one of the exhibits that you offered in evidence, Mr. Dowdey?

MR. DOWDEY: Yes, Your Honor.

THE COURT: Then of course the plaintiff concedes its authenticity because he has offered it in evidence. I was under the impression that it had been offered.

MR. DOWDEY: Could I hear the answer to that last question?

(The last question was read by the Reporter.)

THE COURT: Well, the plaintiff has offered this in evidence.

BY MISS BACON:

Q. Subsequent to the time you were treated at Bolling Air Force Base in 1955 did you have occasion to consult any non-military phy-

sicians? A. You mean previously in my life or immediately before?

Q. Subsequent to February 1955. A. Oh, after. Excuse me. The question again, please? I'm sorry.

Q. Subsequent to February 1955, Mrs. Harvey, did you have occasion to consult private non-military physicians? A. Yes.

Q. And when did you consult them? A. Well, when we were at Eglin Air Force Base in Florida and I went to a Dr. Wilson in Fort Walton Beach, Florida, and then there was a Dr. Braden in Pensacola whom I went to.

Q. Did you ever make inquiry of any doctors, military or non-military, as to whether your capacity to have children could be restored subsequent to February 1955? A. Only to Dr. Braden before he did this hysterectomy.

Q. And that was in what year? A. That was in 1958. I don't quite understand. May I say something?

THE COURT: If you wish to explain your answer you may do so.

THE WITNESS: Well, it's just that at that point what I was really asking him was not whether I could have children, because I was under the opinion that there wasn't anything there to have children with, but I remember having a conversation with him about whether it was necessary to just do all this other too.

BY MISS BACON:

Q. Then at no time subsequent to 1955 did you seek medical advice with respect to restoring your child-bearing function? A. No, not as such. I was told --

Q. I think we have had the answer. Thank you, Mrs. Harvey.

MR. DOWDEY: Let her answer the question.

THE COURT: You may step down.

MR. DOWDEY: She wasn't permitted to answer all of that question.

THE COURT: Do you have anything else?

MR. DOWDEY: She was not permitted to give a full answer to that question.

THE COURT: Very well, you may answer the question. Surely. I thought she had finished it. You may finish your answer.

THE WITNESS: Miss Bacon had asked me if I asked anyone about

restoring my child-bearing capabilities, and I didn't per se because I had no reason to believe this was possible, but when I was told that I was pregnant without any Fallopian tubes at all, then I naturally had a conversation with the doctor who told me this, and he ended up by saying that I was cracking up, that this was impossible. But that is the only conversation that there was.

142 THE COURT: May I make an inquiry, Miss Bacon, in order to clarify my own thinking. Of course I don't know too much about these matters. It isn't the contention of the Government that there is some medical way of restoring the child-bearing faculty, is it? The Government doesn't content it is possible?

MISS BACON: No.

THE COURT: I thought not.

MISS BACON: I have no further questions.

THE COURT: Any redirect examination?

MR. DOWDEY: I have no further questions.

THE COURT: You may step down.

(Witness stepped down.)

MR. DOWDEY: That concludes the plaintiff's case.

I wish the Court would indulge me an opportunity to look through some of these documents. There have been a number of them that I would like to check at some occasion.

143 THE COURT: You can do that after court recesses this afternoon, if necessary. You mean you think you might have overlooked offering something?

MR. DOWDEY: Yes.

THE COURT: Well, that is entirely reasonable. You can do that after court recesses and, if necessary, I will reopen your case just for the purpose of allowing you an opportunity of offering any additional document.

MR. DOWDEY: Thank you.

THE COURT: You may proceed, Miss Bacon.

MISS BACON: At this time, if Your Honor please, I would move

for a judgment, my understanding being the plaintiff has rested his case. I would move for judgment for this reason, that the plaintiff has failed to prove the essence of his case, to wit, that there was any wrong done to this plaintiff.

THE COURT: Miss Bacon, I think this is a case where it is better for the Government to put in testimony. A case such as this is not an ordinary negligence case like an automobile accident. A case such as this involves the professional reputation of a professional man, and I think it would be useful to have the entire testimony, especially as this is a non-jury case.

I presume you are ready to put in expert testimony on the question as to whether the course pursued by the doctor was the proper one and in accordance with the usual procedure. I am going to suggest that you
144 better put in testimony and I will reserve decision on your motion until after the close of the case.

146 STAFFORD W. HAWKEN
called as a witness by the Government, having been duly sworn, was examined and testified as follows:

147 DIRECT EXAMINATION

BY MISS BACON:

Q. Dr. Hawken, would you state your full name and your address for us, please? A. Stafford Wendel Hawken.

Q. And are you licensed to practice here in the District of Columbia? A. I am.

Q. Where is your office in the District of Columbia located? A. At 1150 Connecticut Avenue.

Q. And for how many years have you been engaged in practice in the District of Columbia? A. Since 1933.

Q. And have you been engaged in a specialty during that period? A. I have.

Q. And what is your specialty? A. Obstetrics and gynecology.

148 Q. And are you certified in that specialty? A. I am.

Q. And by whom are you certified? A. The American Board of

Obstetrics and Gynecology.

Q. And could you tell us when you were certified -- Can you tell us where you trained, Doctor? A. At the Providence Hospital in the District of Columbia I served my internship, and my residency at the Columbia Hospital for Women.

Q. And where did you receive your medical education? A. At Georgetown Medical School.

Q. And are you presently engaged in any teaching, Doctor? A. I am a Professor of Clinical Obstetrics and Gynecology at the Georgetown Medical School.

Q. And do you have associations with any of the hospitals here in the District of Columbia? A. I do.

Q. And with what hospitals are those? A. I am Chairman of the Department of Gynecology at the Columbia Hospital, I am an attending gynecologist at Georgetown Hospital, I am a consultant at the Veterans Administration facility, I am a sometimes consultant at Andrews Air Force Base.

149 Q. And have you had occasion to write in the field of your specialty, Doctor? A. A few papers.

Q. And do you presently recall those papers or for what occasion they were prepared or presented? A. Well, a study comes to mind of appendectomy during pregnancy, a study of the complications of torsion of the bowel during pregnancy, which is due to be published shortly.

Q. Doctor, have you ever testified previously in any courts in this jurisdiction? A. Once.

Q. And on what occasion was this? A. This was in an accident case.

Q. Was this within the field of your specialty? A. This was.

MISS BACON: I would respectfully submit that the Doctor is qualified as an expert.

THE COURT: Oh, yes, he is highly qualified.

THE WITNESS: Thank you.

BY MISS BACON:

Q. Doctor, you were engaged in practice in the District of Columbia in 1955, is that correct? A. I was.

Q. Can you tell us, Doctor, in the District of Columbia in 1955 what
150 was the accepted practice with respect to repair of Fallopian tubes
following the removal of an ectopic pregnancy in a woman who was 28
years old and who had previously experienced a salpingectomy which
left her without her left Fallopian tube? A. This was not done.

THE COURT: What was not done?

THE WITNESS: Repairative procedures.

BY MISS BACON:

Q. Can you tell us, Doctor, do you have an opinion whether in the
following circumstances it was good medical practice in the District
of Columbia to undertake repair of a Fallopian tube: in the case of a
woman who is 28 years old, who gives a history of a prior ectopic
pregnancy followed by a salpingectomy and who has been examined
with the following findings --

MR. DOWDEY: While you are looking that up I have an objection
which I was prevented from making --

THE COURT: You may not interrupt a question; wait until the
question is finished. I suggest that you resume your seat until the
question is finished and the Court will hear your objection then.

You may proceed, Miss Bacon.

Q. -- who was examined via colpotomy procedure, which revealed
151 that the right adnexal structures were brought down into the incision
and a small pregnancy was noted in the ampullary portion, distal portion
would be right, of the right tube, with a small amount of blood oozing
from the fimbriated end; and that on coming to the hospital prior to that
procedure, that this 28 year old woman had complained of black vaginal
discharge, a spotting of blood, a late menstrual period, abdominal
cramps and some rectal pressure; and who was treated by removing
the tubal pregnancy by clamping and ligating the metsosalpin at ap-
proximately the mid portion of the tube proximal to the tubal gestation.

Do you have an opinion, Doctor, as to whether that was good
practice in the District of Columbia?

THE COURT: First answer yes or no. Do you have an opinion,
without stating what the opinion is?

THE WITNESS: Yes, I have an opinion.

THE COURT: Very well. Now.

MR. DOWDEY: This question and the question preceding it are entirely too broad and they ask for --

THE COURT: Don't tell me what they ask. I know what they ask. Just state what your objection is.

MR. DOWDEY: They are too broad and also they do not reflect accurately the situation involved here.

THE COURT: Objection overruled. You may answer, Doctor.

152 THE WITNESS: May I have the first part of the question repeated?

THE COURT: I think we will have the Reporter read either the whole question or as much of it as you would like to have reread.

(The last question was read by the Reporter.)

THE WITNESS: Excuse me, but I think there were two questions in that question, if I may.

THE COURT: You may answer in your own way, Doctor.

THE WITNESS: Well, there was a question at the end as to whether or not this was good medical practice that the patient had an operation in which she had an ectopic and the tube was ligated and removed. That was good medical practice.

The first part says whether a repair, something about a repair to be done. This is what is the confusing part to me.

THE COURT: Suppose you repeat your question very briefly without going into the details.

BY MISS BACON:

Q. Assuming the circumstances which I have given you, Doctor, would you have an opinion as to whether or not it was good medical practice in the District of Columbia to ligate the tube and clamp it,
153 removing the --

THE COURT: Don't use the word ligate. I don't know what it means because it is a medical term.

BY MISS BACON:

Q. -- to cut the tube at approximately the mid portion and remove the portion of the tube next to the tubal gestation? A. Yes, that would be considered good medical practice.

THE COURT: It was good medical practice, in other words, to remove a part of the Fallopian tube under those circumstances, is that right?

THE WITNESS: That is right, Your Honor.

Q. And further, Doctor, would you have an opinion as to whether or not a plastic repair of that tube was in accord with good practice in the District of Columbia in 1955? A. It would not have been.

Q. Assume further, Doctor, that upon examination of the tube involved, by colpotomy procedure, that the doctor observed a distended tube containing a pregnancy of four to five week gestation.

Do you have an opinion as to whether or not it was good medical practice in the District of Columbia in 1955 to attempt to shell out that pregnancy? A. I don't know what would be gained by such.

154 Q. My question, Doctor, is do you have an opinion? A. When you are operating for ectopic you want to get in there and get out and remove the trouble. So you expose it, you see it, here is a diseased tube, you clamp, you remove it and you get out.

THE COURT: I think the question is whether it would have been possible to take the pregnancy out without removing the tube; is that it?

MISS BACON: Yes, Your Honor.

THE COURT: I like to reduce things to lay language so I can understand them.

THE WITNESS: There would be nothing -- this would just be dangerous.

THE COURT: This would be dangerous you say?

THE WITNESS: Yes.

BY MISS BACON:

Q. Can you tell us, Doctor, in what way this would be dangerous?

A. Because you would leave a diseased and bleeding organ, the Fallopian tube.

THE COURT: Well, would it be possible to cure that diseased condition so as to not deprive the woman of the child-bearing function?

THE WITNESS: Only when you had operated by mistake. I mean
155 that the thing had died and was no longer bleeding and it was no reason to operate on this woman, then her tube would still be there and a

diseased tube, but she could have it. But if it was bleeding and she had symptoms and pain, this meant that there was a disturbance in that organ, and the organ, the tube, after the proper care is removed.

BY MISS BACON:

Q. And, Doctor, can you tell us, do you have an opinion as to whether under these circumstances in the District of Columbia in 1955 it was in accord with good medical practice to execute this procedure by a posterior colpotomy? A. This was an accepted procedure. Some did this way, some cut the abdomen open.

Q. Could you tell us, Doctor, what, if any, advantages there would be to using the posterior colpotomy? A. Well, it would mean the abdominal wall, if you would make the diagnosis by colpotomy and then cut a hole in the abdominal wall you are making two holes in the abdominal wall. If you take it out by colpotomy you are making one hole in the abdominal wall. So there is very much less danger in taking it out by colpotomy, as far as the healing process is concerned.

Q. Now, Doctor, can you tell us, please, approximately how large
156 an organ is it with which you are dealing when you are involved with a Fallopian tube? A. I have some x-rays that I could show you.

THE COURT: No, just tell us briefly. How large is the Fallopian tube; is that it?

MISS BACON: Yes.

THE WITNESS: A Fallopian tube may range from five centimeters to ten centimeters long. This is from two inches, to four, four and a half inches.

THE COURT: And what is the diameter?

THE WITNESS: Hairline. The diameter of a normal tube is hairline.

THE COURT: In other words, it is a very thin tube?

THE WITNESS: A thin tube. It distends at its end into an opening that is the ampulla; it means that it widens as it gets to the end.

BY MISS BACON:

Q. Doctor, then calling your attention to the diagram which is on the board, this diagram is not in accord with actual sizes then, is that correct? A. Not at all.

THE COURT: I understood that this was only an enlarged diagram and not drawn to scale. I didn't assume it was drawn to scale.

157

BY MISS BACON:

Q. And can you -- you have described the inside opening of the tube as hairline, Doctor. What is the size of the tube in terms of some article that we may know?

THE COURT: I think I understood what he meant by hairline. It is a very thin tube. I really never knew whether it was thin or not thin until this minute.

MISS BACON: I have no further questions, Your Honor.

THE COURT: Do you wish to cross-examine, Mr. Dowdey?

MR. DOWDEY: Yes, Your Honor. First I would like to move to strike the questions and the answers, the hypothetical question and the answers, because the Doctor did not give the reasons for his opinion.

THE COURT: Motion denied. You can ask him the reasons, if you want to. That is proper cross-examination. They don't have to be inquired into on direct examination.

MR. DOWDEY: I move also to strike the hypothetical questions and the answers because they do not accurately reflect the facts in this case.

THE COURT: You already made that objection. I will deny the motion.

Well, we will take our usual mid-afternoon recess at this time and if you have any cross-examination we will let you cross-examine then.

(Brief recess.)

158

CROSS-EXAMINATION

BY MR. DOWDEY:

Q. Doctor, would you agree with this statement: There are times where if a tubal pregnancy is in the judgment of the operating surgeon considered to be early enough and small enough, that an incision can be made over the pregnancy, the pregnancy shelled out of the tube and the tube reclosed. A. If the question was would I -- let me hear the first part of the question.

(The last question was read by the Reporter.)

A. Only if the pregnancy was known to be dead.

Q. And is that because of moral consideration? A. No, sir.

Q. It's not? A. No, sir.

Q. Why is the life of the fetus important? A. Because the condition would be one of progress and growth if the pregnancy was still alive. If the pregnancy was dead, then there would be no further active bleeding, there might not be further active bleeding if this were done.

Q. If a patient has part of a Fallopian tube remaining, half of the tube remaining after such an operation for an ectopic pregnancy, can it be repaired so as to restore function? A. It is possible.

159 Q. It is possible to repair it? A. It is possible.

Q. And there are physicians that do this in the District of Columbia? A. With knowledge of -- after explaining to the patient her possibilities of it working.

Q. How would you discover -- strike that.

Would such plastic repair be undertaken immediately after the removal of an ectopic pregnancy in the ampullary end of the tube if it was an unruptured ectopic pregnancy? A. This would be very unusual to do.

Q. But it is an alternative, isn't it? A. It is not in my hands, sir.

Q. Not in your hands? A. No.

Q. But there are physicians here that would do that, are there not?
A. There were none in 1955, to my knowledge.

Q. If, Doctor -- strike that. A physician that purported to have this technique as part of his skill, which would preserve the functioning of the tube, should he not discuss this with his patient and let her make the choice as to whether to attempt this restoration?

160 THE COURT: I don't think there is any basis for the question because the Doctor said that back in 1955 this was not done, and we are dealing with 1955, not 1964.

MR. DOWDEY: This is cross-examination and I think --

THE COURT: I understand this is cross-examination, but your question is based on a misinterpretation of the Doctor's answer.

MR. DOWDEY: Well, how did I misinterpret --

THE COURT: I am going to exclude that.

BY MR. DOWDEY:

Q. It's true, is it not, that as far as repair is concerned if the

location of the unruptured ectopic pregnancy is in the ampullary end, this would be the easiest part to repair, would it not?

MISS BACON: Objection. Again he is asking a question which assumes repair was made in '55.

THE COURT: I am going to have the question read. I want to get the exact phraseology of the question.

(The last question was read by the Reporter.)

THE COURT: Of course the Doctor said that back in 1955 they didn't do any repair jobs.

MR. DOWDEY: Must I accept that statement without cross-examination?

161 THE COURT: No, you don't have to accept it, you can refute it, but you can't cross-examine on the basis that that statement is wrong. You have a right to offer evidence to refute that statement. Of course you don't have to accept it, but in your cross-examination you can't assume that it is wrong.

MR. DOWDEY: Well, by that statement I cannot possibly cross-examine him if I have to assume that this is the end of the story.

THE COURT: I have made my ruling.

BY MR. DOWDEY:

Q. Doctor, when the incision is made by colpotomy for a suspected ectopic pregnancy, what kind of field do you have to work in as compared—to treat a tube, as compared with when the incision is by laparotomy? A. A more limited field.

Q. How limited is it? A. Well, you can explore the pelvis and things can be done in this fashion. The condition may be treated in this fashion, ectopic, provided again that conditions are proper for this to be done in that fashion.

The usual sequence of events is the colpotomy wound is made and if there is a profusion of blood, it is not proceeded with. This is at
162 the discretion of the operator. The colpotomy wound might be as much as two inches. This would be the limit that you might have in the vault of the vagina to do this. Then with refractors and lights properly placed the tissues can be brought into view.

Q. In this particular case only half of the tube was removed. Now

isn't that hazardous, to leave that half attached? A. The idea of operating on an ectopic is that you are operating on a bleeding organ. Your idea is to operate on that bleeding organ, stop it from bleeding and get out of there. It has been constantly told us and we teach it all the time in an ectopic you get in and get out.

Q. But if it's a true emergency you go by laparotomy, do you not, if there is extensive bleeding? A. This would be true if there was extensive bleeding.

Q. And in this case there was merely a small amount of ooze, is that correct? A. This is what I understand.

Q. Isn't there a hazard to leaving a part of the tube in? A. With the bleeding controlled—you are operating on this patient because she is bleeding. You stop her from bleeding, try to conserve as much tissue as you can, and get out. This is reasonable.

163 THE COURT: I think you are raising an issue that is not in this case. The issue in this case, according to the plaintiff's theory, is that it was wrong to remove the pregnancy, or, rather, it was wrong to remove the Fallopian tube in order to get rid of the pregnancy.

Now you are discussing or interrogating the witness concerning whether it is wrong to remove a part of the tube and leave the balance in. That is not an issue in this case.

MR. DOWDEY: I believe it is, Your Honor.

THE COURT: Now—

MR. DOWDEY: Indirectly it is.

THE COURT: There is no such thing as an indirect issue.

You know, Mr. Dowdey, I am losing my patience at the fact that every hour or two you raise a different issue. We can't try cases that way.

MR. DOWDEY: Furthermore, this is cross-examination, if the Court please, and I try to—

THE COURT: The Court does not invite any responses to its rulings. The Court is not unmindful of the fact that this is cross-examination, but that doesn't permit you to raise new issues. You had a mistrial once before another Judge because you raised new issues. I am not going to permit that situation again.

164 BY MR. DOWDEY:

Q. I understand you, in your answer to the last question, that you would try to conserve as much tissue as possible in the operation, is that correct? A. You remove—I was thinking of the fact that frequently the ectopic, the ovary is involved, so you get in, you separate the tissues, you take out the diseased. Frequently you may take the whole tube out. There are some times when it is not possible to take the whole tube out. This is within the realm of proper treatment.

THE COURT: At the risk of displaying my ignorance may I ask the question what happens to the part of the tube that is left? Is it just hanging in the air? Is it sealed off?

THE WITNESS: Yes, it seals in the majority of instances. There might be rare times when the lining of the tube may open itself, it may reopen.

THE COURT: But I mean it remains just hanging in space there?

THE WITNESS: No, the tube is supported by the broad ligament next to the uterus. The tube is at the upper end of the broad ligament next to the uterus.

THE COURT: You mean it is attached to the wall?

THE WITNESS: Attached to the lower part of the pelvic structures,
165 Your Honor.

THE COURT: I thought it was just attached at the top and the bottom and was loose otherwise.

THE WITNESS: No, Your Honor.

THE COURT: I see. Thank you.

BY MR. DOWDEY:

Q. In any event, leaving part of the tube in leaves open the possibility of future tubal repair, is that correct? A. This might be done.

Q. Now in some instances you have indicated that it is not possible to remove the whole tube, and I assume that would be because of the restricted field in the colpotomy incision, is that correct? A. This could be possible. The uterus has to be brought down to the wound and the tube has to be visualized and then it would be removed. How much

would have to be removed would depend upon the location of the ectopic. If the man didn't see the ectopic where it was accessible, then he would close the colpotomy wound and operate on it by abdominal method.

Q. Well, if there is an abdominal incision, Doctor, there would be no difficulty in removing the whole tube, would there? A. No, there would be no difficulty in removing the whole tube.

166 Q. But there might be in the case of a colpotomy? A. This is possible.

Q. Isn't one of the risks of leaving the tube in that it may function and produce other ectopics?

THE COURT: This is not an issue in this case. You seem to be bringing in a new issue and I shall not permit it.

The issue that was raised by you in your opening statement was a contention that it was wrong to remove the tube instead of repairing it because thereby the child-bearing function was destroyed. Now you seem to be raising the question as to whether it is better to remove a part of the tube or the whole tube. I am not going to permit you to go into that. You cannot bring in new issues every few minutes.

MR. DOWDEY: I don't think it is a new issue, Your Honor.

THE COURT: Yes, it is.

MR. DOWDEY: I think it is related tangentially to the central issue in this case.

THE COURT: I am going to exclude that.

MR. DOWDEY: Furthermore, as a part of my cross-examination, to seek to develop the reasons for the Doctor's opinion.

167 THE COURT: Well, you have a right to ask him reasons, but I will not permit you to go into this. That is far afield and is not relevant, so don't ask any more questions along that line.

BY MR. DOWDEY:

Q. Doctor, are patients with suspected ectopic pregnancies in the ampullary end of the tube frequently managed conservatively, that is, watched for a period of days to see what develops? A. You could watch an ectopic, yes, but if you have made up your mind that you have got an ectopic there is no reason to wait. This patient has a chance of getting into serious illness. You operate on it. Ectopics may cure them-

selves, this is possible.

Q. Well, we are not talking about ectopics generally, but a very early ectopic in the ampullary end and an unruptured one. A. The only way that you could make such a diagnosis is to visualize it. We are not that smart that we could pick out the part of the tube where the ectopic may be; we consider ourselves fortunate to make the diagnosis.

Q. Well, you would follow, then, perhaps, conservatively by vaginal examinations daily, could you not? A. Only if there was confusion in your mind as to whether or not there was an ectopic.

168 Q. Well, an ectopic that early is very difficult to diagnose, isn't it? A. Mr. Dowdey, if you mean that you are presupposing that this ectopic is in the ampullary end of the tube, this I wouldn't be able to have an idea about. But ectopics in general, a woman may have an ectopic pregnancy before she ever missed a menstrual period.

Q. Isn't the diagnosis of an early ectopic pregnancy a very difficult diagnosis to make? A. Frequently, yes.

Q. And as you have pointed out, without surgical intervention you don't know that there is an ectopic, do you? A. You may be pretty well sure before you operate.

Q. Now what authority do you have that would indicate that the only circumstance in which you would shell out a pregnancy, an early ectopic pregnancy, is where the embryo was dead? A. Practice, observation.

Q. Do you know of any authorities that would so indicate? A. I cannot recall such at the present moment.

Q. Doctor, don't operations for ectopic pregnancy involve a number of moral considerations? A. No, sir.

169 Q. None? A. None.

Q. Are you aware of the fact that many medical ethics books have whole chapters on this subject? A. I have read so.

170 BY MR. DOWDEY:

Q. Isn't one of the considerations in deciding to repair or not to repair the Fallopian tube the possibility of future ectopic pregnancies?

THE COURT: Just a moment. The Doctor testified that in his opinion as of 1955 it wasn't possible to repair the tube. Therefore, this question is improper; it assumes something contrary to the Doctor's testimony. You are not bound by his testimony, but you can't cross-examine him on an assumption that is contrary to his testimony.

MR. DOWDEY: Well, I don't think he—I am just asking him whether or not this is a factor in—

THE COURT: I know what you asked. I am ruling out the question.

Q. Are you familiar with the works of Father O'Donnell at Georgetown University on morals in medicine? A. I do not recall
171 having read such, sir.

Q. Where, as in this case, there is no—one tube has been removed already, prior to the operation—in other words, where the patient only has one tube remaining and an ectopic pregnancy develops in this remaining tube, is it not true that an operation to remedy that situation involves both a sterilization and abortion? A. Well, in the idea of removing a pregnancy, yes.

Q. And in preventing future conception, yes also? A. But you have to presuppose if this tissue was normal it would not have had an ectopic pregnancy.

Q. Well, I am not asking your opinion on the moral question, I am asking you whether or not it is involved. A. An abnormal pregnancy is removed, yes, an ectopic pregnancy is removed.

Q. And it involves sterilization, does it not?

THE COURT: Well, the Doctor has answered that question already. Don't ask it a second time.

MR. DOWDEY: He answered only part of it, if the Court please.

THE COURT: The Court does not invite replies to its rulings.

BY MR. DOWDEY:

Q. Would you agree that ethical analysts conceive that ectopic
172 pregnancy is a classic case to illustrate the problems, moral problems both of sterilization and of abortion? Is that true? A. I have never had this come into the practice of medicine, sir.

THE COURT: You have a right to ask an expert witness concerning statements made by recognized treatises on the subject, of course, but

the way you take a sentence out of context, it doesn't mean anything.

MR. HANNON: If Your Honor please, I think he is examining the Doctor as though the Doctor were an expert in the field of theology, on moral issues.

THE COURT: That is what it seems to me too. I am inclined to agree with you, Mr. Hannon.

MR. HANNON: I object to it.

THE COURT: He is an expert in obstetrics and gynecology and not an expert in morals or theology.

MR. DOWDEY: I quite agree, Your Honor.

THE COURT: I don't invite any responses to my remarks. You may proceed to the next question. The Court does not argue with counsel; the Court makes rulings and counsel have to follow them.

BY MR. DOWDEY:

Q. Is it true, Doctor, that this operation for restoration rather
173 than destruction of the tube is indicated when the opposite tube is either
absent or so obviously diseased as to be non-functioning and the patient
is anxious to continue child-bearing? Is that true?

MISS BACON: Objection. The Doctor has already responded that this was not good practice in the District of Columbia in 1955.

THE COURT: Yes, I am going to sustain the objection, and I don't want that type of question repeated, Mr. Dowdey. The Doctor said that that wasn't done in 1955 and you may not ask him questions on the assumption that it was done. After a while patience ceases to be a virtue.

BY MR. DOWDEY:

Q. In 1955 how extensively was the colpotomy technique employed in the District of Columbia as a therapeutic technique for ectopic pregnancy? A. More occasionally than usually.

Q. In other words, this was not a customary technique in the District of Columbia? A. It depended upon where this man had his training.

Q. And might not the same situation be true with respect to repair of tubal pregnancies, namely, that it would depend on where this man had his training? A. No matter where he had his training he would
174 have to realize that the percentage of success would be less than one in

twenty without the ectopic being present. With the ectopic being present it just gave him that much more difficulty to do. He was operating to do a plastic procedure in the presence of active disease. This is basically not a good surgical principle.

Q. Is that true now as well as in 1955? A. I think in most—in most of the instances it would be unusual that this be done, except if the case was one, as I have outlined before, where there was no further growth to be had of this pregnancy, where it was a dead ectopic. Then a man might proceed and try and restore function or try and maintain function; but he would again know that the possibility was that this woman would have another ectopic because of the fact that the first ectopic only occurred because of the fact that there was some abnormality or disease process present in that tube.

Q. And by leaving in part of the tube he also ran the same risk of another ectopic, didn't he? A. Well, if the end of the tube was tied it would be exceptional that this does open itself; but this does remain a possibility.

Q. And your answer to that would not depend upon whether this was
175 in 1955 or 1964, would it? A. Repairative procedures on tubes—everybody, as far as an obstetrician or gynecologist, is anxious to preserve the function of the female as much as possible, but when he is faced with a situation such as an ectopic pregnancy, as I tried to say before, his idea is to remove the pathologic tissue and get out of there because these patients may be into trouble. It would depend upon the individual patient.

THE COURT: When you say trouble do you mean death?

THE WITNESS: I do, sir. I do, Your Honor.

BY MR. DOWDEY:

Q. Well, is there anything other than the existence of the ectopic pregnancy itself that suggests in this case that the patient was in trouble? A. She had an ectopic.

Q. She was otherwise in good condition, was she not? A. As far as I know.

Q. Surgically? A. As far as I know.

Q. So if repair were in the cards it would be a subsequent opera-

tion rather than at that time, is that your opinion? A. Mr. Dowdey, you mean granting that half of this tube is left, if there was to be a repair should it be done then or should it be done at some subsequent
176 time?

Q. Yes. A. The patient would have to request that this be done, and after outlining to her that maybe she had five to a ten per cent chance of success, if she wanted to undergo such an operation she might find somebody to do it. But basically this would all have to be outlined to the patient first.

Q. You indicate that the chance of successful restoration is one in twenty? A. I think this is generally believed.

Q. Do you have any statistics on that? A. It's generally true that five per cent would be.

MR. DOWDEY: If the Court will indulge me a moment.

(Pause.)

BY MR. DOWDEY:

Q. Might the success rate be as high as twenty-five per cent?

MISS BACON: Objection. I do not believe the question specifies the time, whether this was '55 or present time.

THE COURT: I think the objection is well founded. You have to relate this back to 1955 and not 1964. All science, and medicine included, has progressed very rapidly in the past ten years, you know. I am sure that is true of medicine and surgery.

177 BY MR. DOWDEY:

Q. Well, when you gave your estimate of one in twenty, namely, five per cent success, what year were you referring to? A. If a patient came into my office today and had this procedure done, I would tell her she might have five, ten per cent chances of success.

THE COURT: But suppose it was in 1955, Doctor?

THE WITNESS: I would have told her about five to ten per cent chances in 1955, and no more, and I don't believe we have improved any in fixing tubes since that time, Your Honor.

THE COURT: I think we are a little far afield. The charge made by the plaintiff is that a part of the tube was removed. Whether at a subsequent time somebody could come in and repair the tube has

nothing to do with this case. If such a repair job could be done I suppose it could be done today. I will hear you on that.

MR. DOWDEY: I believe it does have to do with this case because she was not informed of this, and that is so charged in the pretrial statement.

THE COURT: She was not informed that a repair job could be done?

MR. DOWDEY: Right.

178 THE COURT: Let me see if that is in the pretrial order. You know, my difficulty with you has been, from the very beginning of this trial, that every little while there would be a new issue interjected. We just can't try cases that way. As I have said before, you had one mistrial before another Judge back in January.

No, I have the pretrial order before me and I don't see any allegation. I am looking at it hurriedly, of course. If you can call my attention to it I will be glad to have you do it.

MR. DOWDEY: If the Court will indulge me a moment, I am looking for the pretrial statement.

THE COURT: Miss Bacon, is it in the pretrial order? Is any such issue in the pretrial order?

MISS BACON: My view, Your Honor, is that it is not in the pretrial order, and further, that he is confined by virtue of the prior opening statement and the ruling of Judge Pine to three issues.

THE COURT: I am not confined by that. That does not confine me. I will not narrow down the pretrial statement. I think it would be a mistake to do that.

But it is not in the pretrial statement, Mr. Dowdey, and therefore I shall exclude that line of inquiry.

MR. DOWDEY: I haven't found the pretrial statement yet.

179 THE COURT: I have just read it and it isn't there.

MR. DOWDEY: The part that I would direct the Court's attention to is where it says that what was done by the physicians was accomplished without adequate consultation with the plaintiff.

THE COURT: But that is not that point. The point you are now raising is whether somebody should have advised her later on, after

she recovered from the operation, that she could have another operation to repair the tube. That is not an issue in this case.

180 (At 4:05 p.m. trial stood in recess, to reconvene 10:00 a.m., April 16, 1964.)

182 THE COURT: Have you completed your cross-examination of the Doctor?

MR. DOWDEY: Yes, Your Honor. I indicated otherwise last evening, but upon reflection and in light of Your Honor's rulings I have concluded my cross-examination.

THE COURT: The Government may proceed then.

MISS BACON: The Government proceeds, Your Honor, by directing your attention to page 102 of the deposition of Dr. Eavey. * * *

I ask Your Honor to begin with line 3 on page 102.

THE COURT: How far down?

183 MISS BACON: Proceeding until line 3 on page 103.

THE COURT: Very well.

MISS BACON: At this point, Your Honor, the Government rests.

THE COURT: Very well. Both sides rest?

MR. DOWDEY: I would like to reopen my case to offer the documents about which I spoke to the Court yesterday.

THE COURT: Very well.

(Explanatory Supplement to Standards for Hospital Accreditation marked Plaintiff's Exhibit No. 11 for identification.)

MR. DOWDEY: I would like to offer the covering identification and paragraph 6 commencing on page 11 and concluding on page 12 of what has been identified as Plaintiff's Exhibit No. 11.

THE COURT: Yes, but what is it?

MR. DOWDEY: Which are explanatory supplement to the standards for hospital accreditation, and paragraph 6 is an interpretation of standards previously offered.

THE COURT: Very well, you may hand it up.

MISS BACON: I have objection, if Your Honor please, on the
184 grounds of competency and relevance. This is similar to the documents
with which you dealt yesterday.

THE COURT: I think it is relevant but incompetent.

What particular portion are you offering?

MR. DOWDEY: The paragraph 6, Your Honor, which begins on
page 11 and 12, which is an interpretation of their standards for con-
sultation.

THE COURT: Show me the particular paragraph. Mark it lightly
in pencil or ink.

I am going to sustain the objection on the ground this is not
competent proof of what the accepted practice was. Moreover, failure
to comply with a custom as to consultations does not give rise per se to
a cause of action unless you can show that if there had been a consulta-
tion some other course would have been followed.

MR. DOWDEY: I would like to argue that point, if I may, later.

THE COURT: Well, at the proper time.

Now is there anything else?

MR. DOWDEY: Yes, Your Honor. I would also like to offer inter-
pretive matter of the standards of ethics which were admitted into
evidence. These are interpretations by the Judicial Council of the
promulgating authority. I have this in a book and I am offering it with
185 the understanding that we can have the pages photostated and substi-
tuted.

THE COURT: Yes, that is entirely proper.

(Portions of AMA Journal re Prin-
ciples of Medical Ethics, opinions
and reports of Judicial Council
marked Plaintiff's Exhibit No. 12
for identification.)

MR. DOWDEY: The part that I offer, Your Honor, is, of course, the
covering identification, the preamble, Section 6 which appears later on,
and Section 8 and the explanation following Section 8.

THE COURT: What does the Government say?

MISS BACON: The Government objects, Your Honor, on the grounds as stated.

186 THE COURT: Sustained on the same ground.

MR. DOWDEY: That concludes our case, Your Honor.

MR. DOWDEY: I would like to simply direct the Court's attention to just a few matters.

THE COURT: Yes, you may proceed.

MR. DOWDEY: Just the testimony of Dr. Eavey on deposition. The part that I would call the Court's attention to, the first part I would call the Court's attention to—

THE COURT: Just a moment.

190 THE COURT: Is there any evidence that there were two choices open?

You see, in your opening statement you said flat-footedly that there were two choices open to the doctor, one to take out the tube and thereby, in view of the fact that the other tube had been removed, thereby destroying the child-bearing possibility of this lady; and the other choice was to repair the tube. Now I was very much impressed with your statement as made because it seemed to me that if that choice was open to the doctor, of course he should have repaired the tube. The testimony, however, as it has developed, shows that while in some cases it is possible to repair the tube, this was one of those cases in which it wasn't. And I say your opening statement shouldn't have summarized the testimony or the depositions as though they showed that in this particular case there was a choice.

191 I think the courts always have a right to rely on accurate statements by counsel, have a right to assume that counsel are going to be accurate in summarizing the testimony, and you weren't.

MR. DOWDEY: May I say, Your Honor, that the doctor himself described this as an alternative.

THE COURT: He didn't describe it as an alternative in this case. He said that in some cases it is possible to repair the tube if the

pregnancy is early and small enough. And then he said, however, on page 103, it wasn't practicable in this case.

Now you may proceed, Mr. Dowdey.

MR. DOWDEY: Your Honor, on this point, for the context of the last question, namely, whether it was a matter where reasonable specialists in the field might differ, I direct you, if you care to look—

THE COURT: If this is a matter on which reasonable specialists might differ, standing alone that ought to be a reason for throwing out this case because if a matter is such as to which reasonable specialists might differ, then there can't be negligence to make one choice as against the other.

MR. DOWDEY: I think you would be quite right in saying so, were it not that we have an amputation involved, and I think there is an obligation here to take whatever choice would conserve this function.

192 THE COURT: The doctor said in his opinion it was not practicable to do it in this case. In fact, he said that it was only in the exceptional instances where the pregnancy is very early and very small.

Now you may proceed.

MR. DOWDEY: Well, notwithstanding—I mean, with Your Honor's view of the case, in that light—

THE COURT: Well, that is the way I construe the testimony.

MR. DOWDEY: Yes. Very well. The testimony of Dr. Eavey.

May I make one further remark?

THE COURT: Yes. Take all the time you want. I want you to have full opportunity to argue the matter from your standpoint. I was only calling your attention to the fact that, as I view the matter, you didn't accurately summarize the testimony on this point.

MR. DOWDEY: Furthermore, as regards these other matters of consultation and whether or not we would have to prove that a consultation would have resulted in a different course of action being taken, I would like to call the Court's attention to the general principle, as I understand it, of tort law, that where the consequence would necessarily
193 have followed even though the desired action had been performed, then there would be no recovery; but if it might not have happened had the

action been taken, then there can be recovery even though the consequence might have been due to other causes with equal probability.

Now I think it is covered in the Restatement of Torts, Section 432. If the matter would have happened even if the duty had been performed, then the defendant is not liable; but if the injury might have been caused by a breach of duty or by an independent cause, there is liability for the breach.

The classic case, which I am sure Your Honor is familiar with, is the case of the two hunters who both fired a shotgun in the same direction and a man was killed. Both were held liable because while they couldn't establish which one hit him, nevertheless they couldn't prove that their shot did not strike him.

THE COURT: Well, I don't think either one of them could be convicted of a homicide.

MR. DOWDEY: Not of homicide, but of tort liability.

THE COURT: I am not sure whether that case is good law. Do you remember what jurisdiction decided that?

MR. DOWDEY: I really don't know. It's so old—

THE COURT: I know it is an old case. I don't know either. It is
194 an example that is used sometimes, but I am not so sure it is good law. I think a person, to recover damages, would have to show whose gun caused the death. I certainly would be inclined so to hold if I was trying an action for damages here.

MR. DOWDEY: Well, in the instant case I think this principle is followed in the District of Columbia in such cases as *Kendell* against *Gore Properties*, which Your Honor may recall.

THE COURT: I don't recall it by name.

MR. DOWDEY: That was where the house painter was hired without an adequate investigation.

THE COURT: Oh, yes.

MR. DOWDEY: And the Court of Appeals pointed out that it is true enough that even if they had an adequate investigation the woman might still have been assaulted, but, on the other hand, the purpose of the investigation would be to prevent this sort of thing.

THE COURT: That case involved a question of proximate cause.

MR. DOWDEY: Yes. Well, I think that is what we are talking about at this moment. For example, there is a certain analogy here, 195 if I may point it out. To say that appellees may fail to make even the most cursory inquiry and then be allowed to excuse themselves in their ignorance is to say that their recklessness will be exalted. And I would submit, Your Honor, that we are in precisely the same situation here as regards consultation.

To say that a consultant might have agreed with Dr. Eavey's procedure is to simply give the obligation to consult absolutely no efficacy at all.

And I submit, in conclusion, if the Court please, and as the Court remarked at the outset, were we dealing with an ordinary malpractice case, were these matters of judgment of a merely technical nature, then we would have a difficult problem; but involved here are not technical questions at all. Any technical medical question has certainly been resolved by the testimony of Dr. Eavey. What we are dealing with here is: given these facts and circumstances with which he had to work, was it purely a matter of medical technique that he could decide for himself, or was this a matter in which he had to consult with others? Was this a matter in which he had to let his patient have a say? Do we go on the operating table in a circumstance like this and, although there are two schools of thought about it where medicine men might differ, that the most radical solution will be taken? I think not and I think that is what is involved at the core—

196 THE COURT: I would be very much impressed with your case if there were two alternatives actually open to the doctor. In other words, if he could have repaired, safely repaired, without any serious danger of disastrous consequences, if he could have safely repaired this tube and thereby saved the child-bearing function, if he had that as a reasonable alternative in this particular case I think there would be a great deal of merit to your case. But as I see the testimony there is no testimony anywhere that it would have been reasonable, proper or safe practice or possible practice in this particular case to have repaired that tube. That is really the crux of the case, isn't it?

MR. DOWDEY: I think that is central to it, and Your Honor interprets Dr. Eavey's testimony differently than I on that point. I can appreciate the Court's interpretation. However, I do have a different interpretation of his testimony on that point.

In interpreting this testimony, again I would say this, mindful of the difficulties of establishing such a case as this, as Your Honor well knows only by cross-examination was this information elicited at all.

THE COURT: What information?

MR. DOWDEY: The information about the possible choices was
197 elicited only on cross-examination.

I know that Perry Mason frequently has marvelous successes with cross-examining witnesses, but as Your Honor well knows, we mortals must be satisfied with something less.

THE COURT: Mr. Dowdey, Perry Mason is only a fictitious character and I doubt very much whether there are many lawyers who could perform some of the intellectual gymnastics that he performs and most of them are not suitable to a real trial. Frankly, I strongly disapprove of Perry Mason and similar television plays because they are a diatribe on court procedure and they convey a wrong impression to the public of the law. It is as though some quack doctor was to put on a play as to what goes on in a hospital and emphasize this, that or the other thing and create a horrible impression or an impression, if not horrible, that something is done that is beyond the ken of man. I sometimes wonder why the American Bar Association doesn't take a stronger attitude with those things. I am sure that if that sort of portrayal went on so far as the medical profession is concerned the American Medical Association would have put its foot down long ago and would have stopped it. But somehow or other the American Bar Association, of which I am a member and which does a lot of good work I think, is a little more supine, is not as forceful as the American
198 Medical Association.

So I am not impressed by the fact that you cannot do the things that Perry Mason is said to have done. I don't think Perry Mason could

do the same things if he was to try a case in real life.

MR. DOWDEY: But I merely point that out by way of contrast.

THE COURT: Oh, I know.

MR. DOWDEY: In cross-examination, as Your Honor well knows, we very infrequently score great victories, that the more usual thing is to get small admissions.

THE COURT: I have often said to lawyers that one of the most fruitless things is to try to cross-examine an expert witness who is a competent expert and is telling the truth as he knows it. I have never yet seen anything accomplished by it.

So I wouldn't approach myself, if I were you, as to that.

MR. DOWDEY: Well, mindful of those difficulties, I think that is a question of reading the testimony of Dr. Eavey, upon which we base our case, in the light of those difficulties and in the light of the admonition that I think the Court of Appeals has given on more than one occasion of the advantage that a physician enjoys in this kind of case.

199 THE COURT: Now I want to say this: I am bound by rulings of the Court of Appeals; I am not bound by their expressions.

MR. DOWDEY: I quite—that may well be.

THE COURT: There used to be a time when the so-called conspiracy of silence perhaps existed on the part of the medical profession, but if so, it is no longer the case because we have many negligence cases against physicians and hospitals where there are reputable doctors of high standing testifying for the plaintiff.

I had a case of mal-practice against a doctor that I tried without a jury just about a year ago which I decided for the plaintiff, and there two very high class doctors gave testimony as to what was accepted practice, which was entirely different from what the unfortunate well meaning defendant doctor did in the case.

So these difficulties are no greater than difficulties in any other case. There used to be those difficulties, but I think they don't exist to the same extent, if at all.

MR. DOWDEY: I might say this in connection with that matter, Your Honor, since Your Honor has mentioned an experience, that in this

case it must be obvious that I have had some very careful medical tutoring and certainly I have consulted with many specialists in this field.

THE COURT: I don't doubt that for a moment.

MR. DOWDEY: However, not a single one of them, although they are close friends of mine, would come in here and testify. They would not even allow me to give their name to my client.

THE COURT: Maybe they wouldn't want to testify because their testimony would not be in accordance with your hopes.

MR. DOWDEY: That is not the situation.

MISS BACON: May it please the Court, at this time the Government would briefly renew its motion for judgment on plaintiff's case, only calling your attention—

THE COURT: I am going to decide the case on the merits. In a non-jury case a motion to dismiss at the close of the plaintiff's case does not quite perform the same function that a motion to dismiss does at the close of the plaintiff's case in a jury trial. In fact, the old equity procedure always involved hearing the entire case on its merits.

201 I am going to decide the case on its merits and I think perhaps I would rather hear you on the merits. As a matter of fact, I think it is more satisfactory to both parties. That is one reason I decided to hear the merits.

MISS BACON: Indeed so, Your Honor. I only wish to bring to your attention our continuing interest and our continuing advocacy of the statute of limitations defense and the fact that plaintiff did not make out a prima facie case.

But turning to the merits, as we have seen them here—

THE COURT: And I am not going to throw it out just on the statute of limitations because that might leave an inference that I thought there was a claim. That is the reason I am going to decide the merits, because somebody's professional reputation is involved here.

MISS BACON: And I believe, Your Honor, after the testimony taken in the course of this trial, that professional reputation stands.

The testimony here from Dr. Hawken was that the practice in this community in 1955 was to proceed as Dr. Eavey did proceed. What was done in the case at bar was in accord with the custom and practice in the District of Columbia in 1955. And as we are well aware, the doctor's duty is one of following the course that is advocated by his brethren in good standing in the community. His is not a duty of outside possibilities, his is a duty of acting in accord with the custom and practice of the community. And indeed this was done in this case.

There is no proof offered here that Dr. Eavey acted in a manner contrary to that practice or there is no proof that there was an alternative in this case, that there was a genuine choice.

There is no proof, further, that even if there had been a choice, that it would have given a different result.

The Government respectfully submits, Your Honor, that in this case it is plaintiff's unfortunate affliction and not the treatment that was rendered which is the cause of this situation. She is a woman who had had two ectopic pregnancies. As Dr. Hawken testified, the treatment for these circumstances is to get in and get out, that dallying or waiting is a dangerous proposition.

She was definitely treated for the unfortunate circumstance which she presented and she was treated in accord with practice, and on that basis we seek judgment.

THE COURT: Miss Bacon, one of the exhibits introduced by the plaintiff, one of the photostatic exhibits, was a consent to the operation in the hospital. I would like to locate that. What number was it? Have you got it?

MISS BACON: Yes, I do have it, Your Honor. That document was numbered Plaintiff's Exhibit 1-A-15.

THE COURT: This is not very legible or the photostat is poor. The consent is to abdominal surgery and/or colpotomy. Very well.

Colpotomy refers to the manner of reaching the organ, does it not?

MISS BACON: That is correct. Colpotomy is the procedure of

making the vaginal incision, bringing the tube down to where it may be viewed.

THE COURT: Instead of entering through the abdomen.

MISS BACON: That is correct.

And of course, I think it is particularly significant in this case, Your Honor, that the doctor did bring down the tube, he viewed it, he saw the pregnancy. There is no doubt in this case as to the pregnancy of the plaintiff. It was observed and viewed and excised.

There is no doubt either in this case when the doctor looked at this tube, that he found it to be a distended and distorted tube, one
204 which was not a fit subject for repair, that it was a diseased tube, and he took out the portion which was diseased.

We further submit, Your Honor, that talking of this case in terms of sterilization or abortion does not prove a case. As Dr. Hawken said, sterilization may be involved, but it is indirect. And on this point, if Your Honor please, there has been no firm proof that she was in fact sterilized. One of the exhibits to which we call Your Honor's attention was a letter of Dr. Wilson, who stated that he found her to be pregnant and that she suffered a miscarriage subsequent to this operation.

THE COURT: May I see that letter? Of course, this letter was introduced in evidence by the plaintiff.

MISS BACON: Yes, Your Honor.

THE COURT: It is a mystery, though, because according to the testimony Dr. Eavey assumed the result of the operation would destroy her child-bearing faculty.

MISS BACON: Yes, Your Honor. I believe his testimony was that there was a possibility, which he would consider remarkable, but nonetheless a possibility, of subsequent pregnancy.

THE COURT: I wonder if Dr. Wilson has his dates correct.

MISS BACON: I think these issues are really tangential.

205 THE COURT: I think that is a tangential issue.

MISS BACON: Everything else falls when there is testimony that what the doctor did was in accord with good practice.

THE COURT: Would you like to say anything in reply, Mr. Dowdey?

MR. DOWDEY: Only to answer Your Honor's question about the date that Dr. Wilson has.

THE COURT: Yes. Of course, you offered the letter in evidence, and it is a little bit of a mystery to me.

MR. DOWDEY: The date, Your Honor, is incorrect in that letter. That is Exhibit 7, is it not, that you are looking at?

THE COURT: Yes, Exhibit 7.

MR. DOWDEY: That was subsequently corrected. We had a more contemporaneous letter of Dr. Wilson in Exhibit 8.

THE COURT: Is that in evidence?

MR. DOWDEY: Yes, that is in evidence.

THE COURT: Yes, that is the photostat of the handwritten letter.

MR. DOWDEY: That is correct. And you will notice, I think, it indicates it was about a year before—

THE COURT: This letter is not dated, is it? Is this Exhibit 8?

206 THE DEPUTY CLERK: Yes, Your Honor. Just this page of it was admitted.

THE COURT: That letter is not dated, is it?

MR. DOWDEY: No, Your Honor, but it says—

THE COURT: It says about one year ago.

MR. DOWDEY: It is addressed to Dr. Braden, I believe. At the time of treatment it shows by other evidence that that was in February of 1958 that Dr. Braden undertook to treat her.

THE COURT: But this says about one year ago.

MR. DOWDEY: That would have been in '57.

THE COURT: Yes, but the operation here was in '55, was it not?

MR. DOWDEY: That is correct, Your Honor.

THE COURT: So I don't see how Exhibit 8 contradicts anything in Exhibit 7. Rather, it confirms it.

MR. DOWDEY: Yes. Well, Exhibit 7 said it was in '55 or '56.

THE COURT: No, but the point of the two letters of Dr. Wilson is that, according to Dr. Wilson, the plaintiff did become pregnant on one occasion after the operation performed on her by Dr. Eavey. What do you say about that?

207 MR. DOWDEY: What I say about it is that it demonstrates that Dr. Eavey should have informed this patient more fully of what had been done to her and—

THE COURT: Just a moment. The gravamen of your case is that Dr. Eavey performed an operation which caused her to become sterile. Now you offer the letters from Dr. Wilson which show that she is capable of procreation.

MR. DOWDEY: No, that is not true.

THE COURT: Why not?

MR. DOWDEY: It shows that the situation came up where repair might still have been attempted had he informed her of this possibility.

THE COURT: Well, she did become pregnant after—

MR. DOWDEY: Well, we don't know.

THE COURT: You offered Dr. Wilson's letter in evidence.

MR. DOWDEY: We also offered the testimony of Dr. Eavey, who was confronted with this very testimony.

THE COURT: What was the purpose of offering Dr. Wilson's letter in evidence?

MR. DOWDEY: To show how important it was that she be informed, particularly about these possibilities and the fact that half of the tube had been left in.

208 THE COURT: I am afraid that Dr. Wilson's letters do you more harm than good because if there was a cause of action, that would mitigate the damages very much because according to Dr. Wilson's letter she conceived on at least one occasion after this operation. Therefore, the operation did not destroy her child-bearing faculty.

MR. DOWDEY: Dr. Eavey was confronted with that on his deposition and he said that he would not believe that she had conceived, although confronted with Dr. Wilson's—

THE COURT: But you offered the letter in evidence and I presume you wanted me to accept it.

MR. DOWDEY: I do.

THE COURT: If the defense had offered it in evidence and you objected to it, I would have excluded it, but you offered it in evidence.

MR. DOWDEY: No, I offered it into evidence and I say it illustrates —Take this consideration, Your Honor: if this physician had been advised that part of the tube remained, then even at that late date something might have been done. But they were proceeding on the assumption that both tubes had been removed.

THE COURT: But the gravamen of your action is that an operation was performed comprising the removal of a part of the Fallopian tube, 209 as a result of which the plaintiff was rendered sterile and incapable of conceiving. That is the gravamen of your action. You can't keep changing the gravamen of your action every hour or two.

MR. DOWDEY: Well, Your Honor has expressed himself on that point and I don't—

THE COURT: Yes, I have.

MR. DOWDEY: —and I don't think it would be helpful for me to reply.

THE COURT: No.

210

OPINION OF THE COURT

THE COURT: This is an action against the United States under the Federal Tort Claims Act. The basis of the action is that the plaintiff, the wife of an Air Force officer, was a patient at the Bolling Air Force Hospital maintained by the United States and that an operation was negligently performed on her by a medical officer of the Air Force, for whose negligence the Government is responsible on the theory of master and servant relationship.

The basic facts are not in dispute. In February 1955 the plaintiff, who was, as stated, the wife of an Air Force officer stationed at Bolling Air Field, went to the Bolling Air Force Hospital because of severe abdominal pains. She was examined by Dr. James L. Eavey, a medical officer of the Air Force who was on duty at the time. The plaintiff told him that two years previously she had had a pregnancy in one of her Fallopian tubes and that as a result of an operation that tube had been removed. He questioned and examined her and came to a tentative conclusion that she had another pregnancy outside of the womb known in the medical science as an ectopic pregnancy, and that possibly

the other Fallopian tube was involved. He advised an exploratory operation to be performed immediately.

211 She executed a formal consent to abdominal surgery and/or colpotomy, the term colpotomy being a method of approaching the female organs through an incision in the vagina. She was prepared for an operation after she was told by the doctor that he was reasonably sure that she had another ectopic pregnancy but that it was necessary to see it in order to make sure. She finally was taken to the operating room after the preliminary procedures that are usually performed prior to an operation had been completed and was placed under an anesthetic.

Dr. Eavey performed an operation. He found that there was a pregnancy in the remaining Fallopian tube and he removed a large portion of that tube, which presumably rendered her sterile and incapable of bearing children.

Dr. Eavey saw her shortly after she came out of the anesthetic told her that he had removed the remaining Fallopian tube, and in response to an inquiry on her part he informed her that the result of the operation was that she could not have children.

It might be said in passing that at that time the plaintiff had been twice married but had never given birth to a live child.

212 The gravamen of the action is that the doctor, instead of taking out a part of the Fallopian tube and thereby destroying the child bearing function, should have repaired the tube after removing the pregnancy out of it.

The Court appreciates that the effect on a young woman whose child bearing function is destroyed is very serious. The procreating function is one of the fundamental functions of mankind. The question in this case, however, is whether the result was due to a misfortune caused by nature or by some fault for which the doctor is to blame.

The basic principles of liability for negligence or alleged negligence on the part of a physician or surgeon are well established and need be recapitulated very briefly. A doctor does not guarantee results, any more than a lawyer guarantees that he would win a case.

A doctor, however, is required to use all the reasonable skill and be armed with all the reasonable knowledge prevailing in his specialty or in his branch of the profession at the time and in the vicinity in which he practices. He is also charged with the duty of performing his work carefully.

The pre-trial order and the opening statement of plaintiffs' counsel indicated that plaintiff was going to demonstrate by proof that it was reasonably possible to have repaired the Fallopian tube instead of taking it out or removing it in whole or in part, and that in view of the seriousness of the consequences, there being such a choice open to the
213 doctor, he should have taken the course that would have less disastrous consequences and repaired the tube after removing the pregnancy out of it. There was a complete failure of proof on that point. There was no proof whatever that it was reasonably possible to follow this alternative in this case.

The plaintiff took the doctor's deposition and the doctor testified, in effect, that it is possible to make an incision in the Fallopian tube, take out or shell out the pregnancy and then repair the tube in a case in which the pregnancy is very early and very small, but not otherwise. He also testified, and his deposition was read in evidence by plaintiff, that in his judgment at the time this was not a possibility and not warranted in the instant case.

No proof was introduced by the plaintiff that was competent and admissible as to what the proper course or the usual course was and that prevailed in the medical profession at the time and place where the operation took place. There was no proof that the doctor departed from proper procedure and proper standards that were accepted in his profession at the time.

It was claimed in behalf of the plaintiff that the doctor was under an obligation to undertake a consultation with another doctor. There is evidence, however, tending to show that the situation was an
214 emergency one that had to be handled promptly because the woman's life was in possible danger. But in any event, failure to engage in a consultation with another doctor does not give rise to a cause of action

unless there is some evidence that would justify an inference that had there been a consultation a different course would have been advised. No such evidence exists.

The Government moved to dismiss the complaint at the close of the plaintiffs' case. The Court was indeed impressed with the fact that there was a complete failure of proof on the part of the plaintiff and that the Court could indeed have dismissed the complaint on that ground at the close of the plaintiffs' case. In view of the fact, however, that this was a non-jury trial it seemed to the Court that it would be in the interest of justice to revert to the old historic equity procedure of hearing the entire case on the merits and disposing of all the issues. This view was based in the mind of the Court on several grounds. First and foremost, the case involved, like most negligence actions brought against a member of a profession, the reputation of a professional man.

In her opening statement Government counsel indicated that the Government had evidence that it would introduce, if necessary, to the effect that what the doctor did was to follow the accepted standards of his profession. It seemed to the Court that if that evidence was available it should be taken because to dismiss the case for failure of proof would be only a partial vindication of the doctor's reputation.

In addition, plaintiffs' counsel argued that there was what sometimes has been referred to as a conspiracy of silence on the part of the medical profession, making it impossible for him to obtain proof. While it is the view of this Court as a result of trying quite a number of cases involving physicians and surgeons and hospitals, that nowadays contentions of this kind are exaggerated, nevertheless the Court thought that it would be in the best interests of all concerned to hear all of the facts, and if there was medical testimony available from somebody other than the doctor himself, it ought to be taken. That is the reason why I reserved decision on the motion to dismiss and asked the Government to put in its evidence.

The Government having put in its evidence and this being a non-jury case, rather than decide the matter on the basis of the motion made at the end of the plaintiffs' case, as perhaps would be required in

a criminal trial, the Court is going to decide the case on the merits and dispose of all the issues on the merits.

The Government called Dr. Stafford Hawken, a leading expert
216 in this locality in the fields of obstetrics and gynecology. He expressed firmly as his opinion that in the District of Columbia in 1955, when the operation in this case was performed, it was not the accepted practice to repair a Fallopian tube following the removal of an ectopic pregnancy and that good medical practice required the removal of a portion of the tube under the circumstances. He further expressed as his opinion that to shell out a pregnancy would be dangerous, possibly fatal to the woman, and that shelling out was proper only if the pregnancy was known to be dead, as well as being very early and small. He also expressed as his opinion that repair of a Fallopian tube is sometimes possible after a part of it is removed, but the chances of success are about one in twenty.

In view of the testimony on both sides the doctor was obviously not guilty of any negligence or mal-practice, but on the contrary, pursued the accepted and standard practice recognized in the profession in the District of Columbia as of 1955, and the Court so finds as a fact.

There are a number of legal issues that are involved in addition to the factual issue and the Court will dispose of them, although its decision on the facts might be sufficient to dispose of the entire case.

The Government raised two legal objections. One is that the
217 cause of action asserted by the plaintiff was assault and battery rather than negligence and that no action lies against the United States under the Federal Tort Claims Act for assault and battery. On this point the Court disagrees with the Government. While there are some cases which hold that performing an operation which has not been consented to constitutes an assault, there are cases also holding that it is negligence as well. But in any event, it is not necessary to decide that in this case because what the physician did in this instance was not perform an unconsented to operation; he in effect undertook to perform whatever operation was found to be necessary, and the removal of a part of the Fallopian tube was within that undertaking and therefore it was not an assault.

There is also the defense of the two year statute of limitations which applies to all Federal Tort Claims Act cases. On its face this action is barred by the statute because this action was instituted on February 24th, 1959, while the operation of which complaint is made was performed on February 15th, 1955, over four years previously to the institution of this action.

In his opening statement counsel for the plaintiff indicated that he would show by evidence that the plaintiff did not discover the wrong, 218 or alleged wrong, that had been committed until within the two year period prior to the institution of this action. It is not necessary to determine for the purposes of this case whether the period of limitations begins to run from the discovery of the negligence or from the date of the negligence itself because there was a complete failure of proof to show that the plaintiff discovered the negligence within the two years prior to the institution of this action. Admittedly she knew the day of the operation that her Fallopian tube had been removed. There was no later discovery of the alleged wrong. She knew of the fact that the operation had taken place and that the Fallopian tube had been partially removed the very day that this was done. Plaintiffs' counsel claims, however, that she did not discover until later that the doctor might have repaired the tube instead of removing it and that therefore the period of limitations does not commence to run or did not commence to run until that discovery. Well, there are several answers to that. In the first place, it has not been established that this alternative of repairing the tube existed in this case. In the second place, the cause of action is the removal of the part of the Fallopian tube on April 15th, 1955, not the fact that someone later on apparently advised the plaintiff that that might have been avoided. Finally, there is no proof as to when she 219 first conceived the notion or was advised by somebody that her condition might have been cured by a repair of the tube.

For all of the reasons heretofore stated the Court will render judgment for the defendant dismissing the complaint on the merits.

A transcript of this oral decision will constitute the findings of fact and the conclusions of law.

[Filed April 30, 1964]

ORDER AND JUDGMENT

This cause having come on for hearing before the Court without a jury on April 14, 1964, and the Court having heard the cause and having ordered that a transcription of its oral opinion of April 16, 1964, as supplemented, be filed as the findings of fact and conclusions of law pursuant to Rule 52 (b), Federal Rules of Civil Procedure, it is by the Court this 30th day of April, 1964,

ORDERED that judgment be and the same hereby is entered in favor of the defendant dismissing the complaint with prejudice and awarding costs in favor of the defendant.

/S/ ALEXANDER HOLTZOFF

United States District Judge

[Certificate of Service]

MOTION TO SUPPLEMENT FINDINGS
OF FACT AND CONCLUSIONS OF LAW

Comes now the defendant by and through its attorney, the United States Attorney for the District of Columbia and requests that the Court supplement the findings of fact and conclusions of law set forth in its opinion on April 16, 1964 for the following reasons:

1. The facts elicited at trial support the additional findings and conclusions.
2. The additional findings and conclusions are necessary to dispose of all the issues which were raised by the parties.

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[Certificate of Service]

[Filed April 29, 1964]

SUPPLEMENTAL FINDINGS OF FACT
AND CONCLUSIONS OF LAW

This cause came on hearing by the Court without a jury. The Court, having heard the cause and having rendered an oral opinion, ordered that its opinion dated April 16, 1964 stand as the findings of fact and conclusions of law. However, pursuant to Rule 52(b), Federal Rules of Civil Procedure, the Court this 29th day of April, 1964 makes the following additional findings and conclusions:

- ~~1. Plaintiff has failed to prove that in fact she was rendered sterile or incapable of bearing children by acts of the defendant on February 15, 1955.~~
1. 2. Plaintiff's allegation that defendant failed to inform her that a portion of her right fallopian tube remained was made for the first time at trial during defendant's case. This allegation was not included in the complaint, the pretrial order or the opening statement and cannot now be raised at this time. Over nine years have passed since the date of the surgery about which she complains and over four years have passed since the filing of the complaint.
2. 3. ~~Even if this new allegation were before the Court, Plaintiff has failed to prove that she sustained any injury as a result of alleged failure to inform. Plaintiff offered no evidence, by expert testimony or otherwise, to show that a subsequent repair of the remaining portion of the right fallopian tube was possible in her case. Plaintiff has failed to prove that even if she had been informed, a different result could have been achieved in her case.~~
3. 4. Plaintiff's evidence failed to show that the doctor violated any duty owed to plaintiff by his alleged failure to inform her of an allegedly possible repair. She offered no expert testimony to prove that the doctor acted in a manner contrary to good medical practice in the District of Columbia in 1955. No evidence suggested that it would have been

good medical practice in the District of Columbia in 1955 to attempt a tubal repair in cases where a woman had experienced two miscarriages and two ectopic pregnancies.

- 4.5. The evidence adduced by defendant proves that repair of plaintiff's right fallopian tube was not possible. ~~Dr. Eavey, the treating physician, testified that in his judgment repair was not possible. By plaintiff's own testimony a Dr. Braden observed the remaining portion of the tube in 1958 and proceeded with a hysterectomy, not a repair of the tube.~~

/S/ ALEXANDER HOLTZOFF
United States District Judge

OPPOSITION TO DEFENDANT'S MOTION FOR SUPPLEMENTAL FINDINGS OF FACT AND CONCLUSIONS OF LAW

Respecting the several paragraphs of defendant's proposed supplemental findings of fact and conclusions of law, plaintiff shows:

1. There was abundant evidence that plaintiff was sterilized, the principal evidence being given by defendant's own surgeon, Dr. Eavey. There would have been a great deal more evidence on this subject had not plaintiff's medical condition and treatment subsequent to the operation of February 15, 1955 been excluded as irrelevant.

2. Plaintiff's deposition of January 6, 1960 shows counsel for the government asking the following questions and receiving the following answers from plaintiff:

Q. And the complaint further says that knowledge or information respecting this negligent and careless treatment that you received there was withheld from you, and that you didn't learn about it until February of 1958.

Now, what I want to know is: who had this knowledge of your careless and negligent treatment, and who was it that withheld it from you?

A. It was a matter of the full amount of information not being given. In other words, when somebody says, "I had to remove a tube," you think that means all of it. I had no way of knowing that it wasn't so until another doctor looked in and saw that it wasn't all gone.

Q. So, that this refers to the fact that part of the tube was left in you when Dr. Eavey or some other doctor didn't tell you about it?

A. Yes.

Q. Yes?

A. Yes, in part.

MR. DOWDEY: In Part?

THE WITNESS: Yes; other things, too.

See also pp. 27, 41-43, 45.

The pre-trial order specifies as one of the acts of negligence:

"What was done by the physicians was accomplished without adequate consultation with the plaintiff"

And defendant objected because:

"The nature of plaintiff's consultation with her doctor. . . [was] known to plaintiff in 1955."

Of course, the problem is not what was communicated, but the facts which could or should have been communicated. These facts, like practically everything else in this case, are matters peculiarly within the knowledge of defendant's physician, Dr. Eavey.

Thus, in opening statement, plaintiff's counsel put the question broadly:

"To what extent must he consult with his patient?"

The general obligation of a physician to fully inform his patient was discussed as well as the importance of a full explanation where sterilization is involved. Further illucidation was not desired by the court at that time.

3-5. A great deal of evidence establishes that subsequent repair

of the remaining portion of the right Fallopian tube was possible. It was even admitted by Dr. Hawken, but plaintiff's counsel was not permitted to pursue the subject further on cross-examination. The hysterectomy in 1958 was the consequence of infection. It probably resulted from failure to obtain proper medical treatment because plaintiff was under the erroneous impression, and so informed her physicians, that both Fallopian tubes had been removed. (See Plaintiff's Exhibit 7.) Defendant was successful in having most of the evidence on this subject excluded as irrelevant.

DOWDEY AND BARTOW

By /S/ Landon Dowdey

Attorneys for Plaintiff

[Proof of Service]

[Filed June 24, 1964]

NOTICE OF APPEAL

Notice is hereby given that Georgiana Harvey, plaintiff above-named, hereby appeals to the United States Court of Appeals for the District of Columbia Circuit from the final judgment entered in this action on April 30, 1964.

/S/ Landon Gerald Dowdey
Counsel to Plaintiff

Date: June 24, 1964

BRIEF FOR APPELLANT

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 18,823

GEORGIANA HARVEY

Plaintiff-Appellant,

v.

UNITED STATES OF AMERICA

Defendant-Appellee.

Appeal from the United States District Court
for the District of Columbia

United States Court of Appeals
for the District of Columbia Circuit

FILED NOV 13 1964

Nathan J. Paulson
CLERK

LANDON GERALD DOWDEY

1333 G Street, N.W.
Washington 5, D.C.

Counsel to plaintiff-appellant

QUESTIONS PRESENTED

This case involves an operation on a young woman, 28 years of age, which rendered her sexually sterile; that is, deprived her of the right, or more accurately, the chance of having offspring. The basic facts are not in dispute.

In the course of an operation undertaken as a diagnostic procedure, the government physician claims to have found a diseased condition of this young woman's last remaining Fallopian tube, namely, an early ectopic pregnancy. He had a choice of either amputating or repairing this tube, which, in the circumstances, was a choice of preserving or destroying the patient's childbearing function. He chose amputation.

Was this choice of a sterilizing technique a matter committed solely to the medical judgment of the operating surgeon?

a. "Where reasonable specialists in the field might differ" about the possibility of successful repair, was the physician not legally and morally bound to attempt repair rather than destroy the tube?

b. To what extent must he consult with his patient? Must he inform her of such a choice and ascertain her wishes in the matter? Must he inform her that a part of the tube was left intact and that there was a possibility of repair still remaining after the operation?

c. Must the operating surgeon consult with another physician about such a choice?

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

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GEORGIANA HARVEY

Plaintiff-Appellant

v.

UNITED STATES OF AMERICA

Defendant-Appellee.

Appeal from the United States District Court
for the District of Columbia

BRIEF FOR APPELLANTS

JURISDICTIONAL STATEMENT

This is an appeal to review a final judgment of the United States District Court for the District of Columbia. Jurisdiction in the District Court was based on 28 U.S.C. 1346(b) and 28 U.S.C. 2671 et seq. (The Federal Tort Claims Act) and the general legal and equity powers of that court under Sec. 11-305 and 11-306 of the D.C. Code, 1961 Ed.

Judgment was entered April 30, 1964 in favor of defendant, United States of America. An appeal was duly noted June 24, 1964. The United States Court of Appeals for the District of Columbia Circuit has jurisdiction to review said judgment under 28 U.S.C. 1291.

STATEMENT OF THE CASE

This is an action against the United States under the Federal Tort Claims Act.

The case involves an operation on a young woman, 28 years of age, which rendered her sexually sterile; that is, deprived her of the right, or more accurately, the chance of having offspring.

As stated by the trial court, "The basic facts are not in dispute" (J.A. 201).

February 15, 1955 plaintiff Georgiana Harvey, then age 28, went to Bolling Air Force Base Hospital in Washington, D.C. As the wife of an Air Force officer, she was entitled to medical care there. She had never been in a military hospital before. She first went to the clinic, sometime around noon.

The cause of her visit was a recent experience which she described as a "small show of blood at the wrong time" and "mild discomfort." Nevertheless, because of a harrowing emergency experience with a ruptured ectopic pregnancy¹ two years previously, she was frankly ap-

¹ Most of the medical and anatomical terms are familiar or explained sufficiently in the body of the brief. However, for convenience, a special ANATOMY AND MEDICAL GLOSSARY, taken directly from the testimony of the government physician involved, has been included at the end of this brief, referenced G1, G2, etc.

prehensive of a recurrence, although her symptoms in no way resembled in acuteness her former condition (J.A. 158-161).²

The trial court's opening narrative sums up what took place after plaintiff's arrival at the out-patient clinic (J.A. 201-202).

"She was examined by Dr. James E. Eavey, a medical officer of the Air Force who was on duty at the time. The plaintiff told him that two years previously she had had a pregnancy in one of her Fallopian tubes and that as a result of an operation that tube had been removed. He questioned and examined her and came to a tentative conclusion that she had another pregnancy outside of the womb, known in the medical science as an ectopic pregnancy, and that possibly the other Fallopian tube was involved. He advised an exploratory operation to be performed immediately.

"She executed a formal consent to abdominal surgery and/or colpotomy, the term colpotomy being a method of approaching the female organs through an incision in the vagina. She was prepared for an operation after she was told by the doctor that he was reasonably sure that she had another ectopic pregnancy but that it was necessary to see it in order to make sure. She finally was taken to the operating room after the preliminary procedures that are usually performed prior to an operation had been completed and was placed under an anesthetic.

² The trial court's characterization of "severe abdominal pain" (JA 201) is at variance with the record. The hospital record of admission (JA 59) and the examining physician's testimony (JA 27-28) indicate no "severe" symptoms. It was the *second* admission, March 22, for "acute peritonitis...at the site of operation" of February 15 that she suffered "acute low abdominal pain" (JA 59, pB-2; JA 63, pA-18).

"Dr. Eavey performed an operation. He found that there was a pregnancy in the remaining Fallopian tube³ and he removed a large portion of that tube, which presumably rendered her sterile and incapable of bearing children.

"Dr. Eavey saw her shortly after she came out of the anesthetic, told her that he had removed the remaining Fallopian tube, and in response to an inquiry on her part he informed her that the result of the operation was that she could not have children."

After this brief statement, the court arrived at the central issue:

1. A possible alternate to sterilization

"The gravamen of the action is that the doctor, instead of taking out a part of the Fallopian tube and thereby destroying the child bearing function, should have repaired the tube after removing the pregnancy out of it.

"The pre-trial order and the opening statement of plaintiffs' counsel indicated that plaintiff was going to demonstrate by proof that it was reasonably possible to have repaired the Fallopian tube instead of taking it out or removing it in whole or in part, and that in view of the seriousness of the consequences, there being such a choice open to the doctor, he should have taken the course that would have less disastrous consequences and repaired the tube after removing the pregnancy out of it. There was a complete failure of proof on that point. There was no proof whatever that it was reasonably possible to follow this alternative in this case.

³ While there was evidence of pregnancy, it is far from conclusive. Like the diagnosis of an unruptured tubal pregnancy (See Anatomy and Medical Glossary, G3, infra) the histology -- determination of the nature of the tissue examined -- is difficult. (JA 43-44) In this instance no pregnancy, actual placental tissue, was found. Dr. Eavey explains this by the circumstance that it might have been expelled from the end of the tube, being too small for him to have observed. All that was found was a hematosalpinx: a swollen tube, inflamed and oozing blood, and a small blood clot (JA 43-44, 62-63). The desidual reaction of the tissue does not establish the location of the pregnancy (JA 24-25).

"The plaintiff took the doctor's deposition and the doctor testified, in effect, that it is possible to make an incision in the Fallopian tube, take out or shell out the pregnancy and then repair the tube in a case in which the pregnancy is very early and very small, but not otherwise. He also testified, and his deposition was read in evidence by plaintiff, that in his judgment at the time this was not a possibility and not warranted in the instant case." (J.A. 202-203).

Defendant's physician did indeed, at one point in his deposition, say that *in his judgment* repair was "not a possibility and not warranted" (J.A. 53). This was the culmination of a series of leading questions by his own counsel which began when Dr. Eavey first made the admission that repair was a relevant and possible alternative *in this case* (J.A. 40-43). Despite repeated interruptions of plaintiff's redirect (cross) examination, Dr. Eavey subsequently admitted again that there had been an alternative to amputation; that the choice to sterilize was in the area of judgment where reasonable specialists in the field might differ:

Q. It is in the area of judgment, in your opinion?

A. Yes, sir.

Q. Where reasonable specialists in the field might differ?

A. True. (J.A. 58)

Furthermore, all the indications for surgical repair discussed by Dr. Eavey were admittedly satisfied in this case.

Certainly the pregnancy was "early enough and small enough" (J.A. 40-41). "The gestation was of four or five weeks duration." There are "not many found much earlier than that, that's true" (J.A. 43).

The gestation was so "minute" it could not be seen (J.A. 44).

The very simplest of repair processes was involved. Because the incipient pregnancy existed entirely in the ampullary portion (outer third) of the tube (J.A. 27, 29), all that was required was "simply cutting [the outer end] off and simply pinning the edge of the mucosa back" (J.A. 40).

Dr. Eavey expressly contrasted the possibility of repairing the tube with the impossibility of preserving the pregnancy (J.A. 53):

Q. . . . In the event it had been possible to preserve Mrs. Harvey's pregnancy in February, 1955, would you have done so?

A. Preserve her pregnancy?

Q. Yes, we have talked about transplanting or shelling the fertilized egg from the tube to the uterus.

A. No, I think you are mistaken. *The idea would not be to preserve the present pregnancy involved. This could not be done. The question involved was her future childbearing function might be preserved by such a plastic procedure.*

[Emphasis added.]

The chief opposition Dr. Eavey had to tubal repair was really a contraceptive one: If the patient conceived her chances of having another tubal pregnancy were higher than the average female population (J.A. 42).⁴ But this was never disclosed to the patient. Had it been, he might have anticipated a violent reaction. Mrs. Harvey "was upset by the fact that her child-bearing function would likely be ended . . . the expected normal reaction from a woman" (J.A. 52).

2. Inadequate Consultation With Patient

This last consideration naturally raises the question of the adequacy of the physician's consultation with plaintiff (J.A. 4).

But the court did not feel obliged to treat this subject directly, since "it has not been established that this alternative of repairing the tube existed in this case" and "there is no proof as to when she first

⁴ Clinical Obstetrics and Gynecology, Vol. 5, "The Effect of Ectopic Pregnancy on Fertility," by Alan Grant, M.D.

Table 5, "The Results of Conservative Surgery for Pregnancy in a Residual Tube" shows of 79 cases in Europe and the U.S., 21 subsequent uterine pregnancies and 3 subsequent tubal pregnancies. Reports from other countries are not comparable.

conceived the notion or was advised by somebody that her condition might have been cured by a repair of the tube" (J.A. 206).

Before the operation, Dr. Eavey told plaintiff that the operation was being undertaken to see if she had "another tubal pregnancy" (J.A. 54). But she was not told that this "tubal pregnancy" was the rarely diagnosed early "unruptured" form, quite different in all its connotations from the ordinary "ruptured" form which suggests an immediate life or death crisis.⁵

Specifically, and most importantly, she was not informed either before or after the operation in February 1955 of the alternatives Dr. Eavey admitted to in his deposition in 1960:

Q. When a woman has a tubal pregnancy what alternative does the doctor have in respect to how he goes about treating her? Are there any?

A. If he establishes such a diagnosis, the only course open is surgical, in most instances requiring the excision of the Fallopian tube, partial or total, or as previously mentioned in testimony, the circumstances where the pregnancy may be shelled out of the tube and the tube allowed to remain as a possibly functioning structure (J.A. 54).

⁵ The mention of "ectopic pregnancy" or "tubal pregnancy" naturally provided plaintiff with a vivid picture of her experience two years previous. Nevertheless, the court excluded all evidence of this experience (JA 161-162). From other parts of the record, however, it is obvious that most ectopic pregnancies when diagnosed are ruptured ectopics and acute emergencies. Indeed, precisely because of the mild symptomatology, diagnosis of an unruptured tubal pregnancy—the kind involved here—is extremely rare (JA 55-56 and see ANATOMY AND MEDICAL GLOSSARY, *infra*, G3). To most people, therefore, and probably to most physicians, "ectopic pregnancy" or "tubal pregnancy" is definitely a scare word, indicating the life or death hemorrhaging crisis usually involved in a ruptured ectopic.

Since the patient should not be "waked up" and consulted during surgery, the only opportunity for explaining the possibility of repair, its risks, and advantages and disadvantages, was before the operation (J.A. 21).

Although, according to Dr. Eavey, repair was a definite and real possibility before the operation (J.A. 54-55), he never informed plaintiff, either before or after the operation (JA. 42-43).

Plaintiff testified:

"I asked him if there wasn't anything that could have been done and he said no" (J.A. 164).

After the operation, Dr. Eavey was "morally certain that I explained to Mrs. Harvey that her right tube had been essentially removed and that for all intent and purposes she would thereafter be sterile as far as childbearing was concerned" (J.A. 31).

There is no question that plaintiff was so informed (J.A. 163). The point is that she was not given the further information that only a part of the tube had been removed, and that it was possible, even after the operation, to have repaired the tube.

Both Dr. Eavey (J.A. 40-43) and Dr. Hawken, an expert witness called by the government (J.A. 177, 185-186), testified that, having left a portion of the tube in, there were available surgical procedures for restoring its function. Neither of them thought the chances of a normal pregnancy after such an operation were very great, but plaintiff's counsel was not permitted to cross-examine Dr. Hawken on this point, nor to draw his attention to statistics of a far more optimistic nature (J.A. 186, and see footnote 4, *supra*).

Both physicians also recognized a duty to inform the patient of this possibility of tubal repair. Dr. Hawken said, "The patient would have to request that this be done . . . but basically this would all have to be outlined to the patient first" (J.A. 186). Dr. Eavey admitted that it would be

his "normal procedure" to inform a patient of this possibility after removing only part of a tube, but, that, in view of his unoptimistic appraisal of the chances of success, he would discourage it (J.A. 42).

In any event, he has no recollection of having informed plaintiff of this possibility (J.A. 42), and most certainly plaintiff was not informed (J.A. 165, 168-169).

Subsequent treatment. Plaintiff did not discover that the removal had been only partial until February of 1958, after she had undergone a complete hysterectomy (J.A. 164). A very stormy series of female complaints followed the operation of February 15, 1955, which the trial court would not admit into evidence (J.A. 153-158); during most of this time plaintiff continued to receive medical treatment by the Air Force, which the trial court would not admit into evidence (J.A. 156-157, 164-165). Throughout all this time, plaintiff was never informed that only a part of the tube had been removed, and never informed that repair was a possibility (J.A. 165, 168-169).

Because of this, she not only did not seek repair, but grossly misled the few non-military physicians she consulted (J.A. 168-169). For example, shortly before the hysterectomy in February of 1958, a civilian physician near the air base where she was then living diagnosed a miscarriage. This is a possibility, although a remote one, when only part of a Fallopian tube has been removed (J.A. 45-49). But when she told him that she had had both tubes removed, he would not believe her and diagnosed her condition as an emotional disturbance (J.A. 168-169). He felt so strongly about this that he even wrote the United States Attorney in this case to that effect (J.A. 88).

Restricted inquiry as to consultations with patient. Although the court made findings on what the physician told plaintiff both before and after the operation (J.A. 201-202), the court generally excluded all evidence and cross-examination by plaintiff's counsel which dealt with failure of

the physician to inform plaintiff: that the removal of the tube was only partial and that subsequent repair was a possibility. The theory of the exclusion was generally that this was "a new issue" (J.A. 186-188).

But the pre-trial order specifically asserted, "what was done by the physicians was accomplished without adequate consultation with the P" (J.A. 4).⁶ The government was well aware of the specifics of the charge, which was based entirely on the deposition of their own physician taken in 1960. Their counsel had made specific inquiry of plaintiff on deposition about the precise point (J.A. 209-210). The only reason the details of the charge were not presented in the opening statement, was that counsel was prevented from doing so by the trial court (J.A. 100, 102-105, 109, 110, 116, 121, 157). The judge even admitted later to having done so (J.A. 108).

Not only was the evidence on this subject excluded and cross examination restricted; the court went on to make specific supplemental findings of what plaintiff "failed to prove" about the possibility of repair when only a part of the Fallopian tube is removed (J.A. 208-209).

⁶ "PLAINTIFF CLAIMS that . . . she was effectively sterilized by the surgical mutilation of her right Fallopian tube Said mutilation consisted of a partial right salpingectomy. P claims that the malpractice and her injuries . . . derived from the negligence of the agents or employees of D in that the mutilation described above was unnecessary . . . ; that what was done by the physicians was accomplished without adequate consultation with P . . . (J.A. 4).

"P asserts further that knowledge or information as to all of the foregoing negligence now claimed by her, or of facts which would furnish such knowledge or information were withheld from her, leading her to believe that the removal of her remaining Fallopian tube was an emergency measure to save her life, such as had been the case when her left Fallopian tube was removed in consequence of a ruptured tubal pregnancy in 1953.

"Defendant . . . denies the withholding of any knowledge or information (J.A. 5)

"As a result of the negligence of the physician, the P had to submit to . . . treatment for what appeared to be a miscarriage in September 1956 and again in the Spring and Summer of 1957, being necessary because of D's negligence and a radical hysterectomy at Sacred Heart Hospital in Pensacola February 12, 1958.

"P claims a permanent injury in the loss of her remaining female reproductive organs with the resultant inability to bear children . . ." (J.A. 6)

3. No Consultation With Other Physicians

The court excluded all of the following evidence as incompetent proof of medical standards in the District of Columbia (J.A. 126-136, 148).

The Joint Commission on Accreditation of Hospitals requires as a minimum standard for hospital accreditation, that the following rules be observed with respect to consultations:

"Except in emergency, consultation with a member of the Consulting or of the Active medical staff shall be required in all major cases in which the patient is not a good risk, or in which the diagnosis is obscure, and in all first caesarean sections, sterilizations, curettages or other operations which may interrupt a known, suspected or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation, the consultant may, and in the case of free patients shall, give his service without charge. This Standard is applicable to all members of the medical staff." (J.A. 79-81)

Any operation upon an ectopic pregnancy involves the interruption of a "known, suspected or possible pregnancy." It involves a sterilization as well if no functioning tube is allowed to remain after the operation. In the case of an unruptured ectopic there is an additional reason for consultation in the "obscurity" of the diagnosis.

In 1955, at the time of this operation, almost every hospital in the District of Columbia, both public and private, was accredited except Bolling Air Force Base Hospital (Joint Commission on Accreditation of Hospitals, List of Accredited Hospitals, 1953, 1955, J.A. 83-86). Thus, this standard was fully applicable throughout the District of Columbia since, as the Joint Commission points out, standards labelled "required" as this one, are "absolute prerequisites" to accreditation

(Joint Commission on Accreditation of Hospitals, Standards for Hospital Accreditation, 1953, J.A. 80).⁷

Other evidence in the record respecting this matter is as follows:

Since Dr. Eavey considered the choice to amputate or repair a matter committed exclusively to "the judgment of the operating surgeon" he felt no need to consult any other physician. Lt. Johnson, who assisted at the operation and did some routine preliminary work, did not participate in establishing the diagnosis or the disposition of the case (J.A. 35, 41, 69-70). He was hardly qualified, having just completed his internship and never having previously seen an unruptured ectopic pregnancy (J.A. 71, 75).

⁷ The standards for required consultations were relaxed somewhat in 1956, but not in respect of sterilization and the interruption of pregnancy (JA 81-82). As the commentary points out (JA 94):

"In considering the Standard of Consultations, one should have clearly in mind what the purpose of this standard is. In the matter of consultations in which the interruption of pregnancy is involved, we are dealing not only with the protection of the patient and the fetus, but also of the doctor and the hospital. No matter how clearly an operative procedure of this nature may be indicated, it is an accepted principle that two or more physicians should agree before it is carried out. We are dealing here with not only professional but also moral and legal considerations. In considering first Caesarean sections and sterilizations, the situation is similar.

The court admitted (JA 158), Principles of Medical Ethics, published by American Medical Association in 1949, dealing with (JA 95):

"Art. III - Duties of Physicians in Consultations

* * *

Sec. 2 - Consultations for Patient's Benefit . . .
 . . . should be candid with patient . . .

* * *

Sec. 7 - Conflict of Opinion . . .
 . . . [If] unable to agree . . . another consultant should be called or the differing consultant withdraw . . . He should be permitted to state [his opinion] to the patient, his relative or his responsible friend, in the presence of the Physician in Charge."

The court excluded the official interpretation (JA 189-190).

There is, of course, no written record of any consultation in this case as the rule requires. Dr. Eavey admits that there was no "formal consultation" (J.A. 35). Lt. Johnson stated that there was no consultation "that I know of" (J.A. 73).⁸

No Emergency. The trial court found:

"It was claimed in behalf of the plaintiff that the doctor was under an obligation to undertake a consultation with another doctor. There is evidence, however, tending to show that the situation was an emergency one that had to be handled promptly because the woman's life was in possible danger. But in any event, failure to engage in a consultation with another doctor does not give rise to a cause of action unless there is some evidence that would justify an inference that had there been a consultation a different course would have been advised. No such evidence exists." (J.A. 203).

But Dr. Eavey did not consider the situation a "true emergency," there being no evidence of massive bleeding suggesting rupture. It was

⁸ Throughout his entire training, internship, and residence at University Hospital in Baltimore, Dr. Eavey never once saw an unruptured ectopic, much less treated one by colpotomy (JA 13-15). The first and only place he had ever seen an unruptured ectopic was at Bolling. There he worked, not under supervision, but on his own, without even so much as a consultation (JA 13-14).

When asked about consultations in the several previous unruptured ectopic pregnancies he had diagnosed and operated upon at Bolling, Dr. Eavey claimed: "There were always other members of the obstetrical-gynecological staff and invariably when diagnosis was finally established at least one of these men were involved." But he admitted there was "no formal consultation . . . as such" (JA 13-14).

The lack of any consultations in Dr. Eavey's few former experiences with unruptured ectopics, immediately draws into question his qualifications.

Strangely enough, Lt. Johnson sought to excuse Dr. Eavey from a consultation because of his experience (JA 75). Actually he thought him much better qualified than he really was (JA 12, 71-72). But Lt. Johnson's point is hardly well taken in any event, since the text of the rule states that the requirement of consultation is applicable to all members of the medical staff. There are no privileged persons excepted from the duty of consultation.

an "emergency only to the degree that if you suspect an ectopic strongly enough the diagnosis should be established and not waited upon, for rupture of an ectopic can be an extremely serious thing On that basis emergency to the degree that I do not believe that days should be allowed to interfere" (J.A. 20-21).

Thus, plaintiff's admission was routine. She walked to the admitting office. The Bolling record shows she was admitted to the hospital at 1:30 p.m., about an hour and a half after first visiting the clinic at noon. After filling out the necessary papers in the admitting office, she went to a number of other different places, walking about through the hospital corridors for blood tests, urinalysis, and other administrative and medical chores (J.A. 160-161).

Lt. Johnson, while recognizing the requirement of a consultation, thought it dispensed with in the instant case because this was an emergency. At first he maintained that he could not conceive of any ectopic pregnancy not being an emergency. Later he admitted that while some ectopic pregnancies would not be emergencies, this was. Finally, he admitted that its emergency character was up to Dr. Eavey, and, as we have already seen Dr. Eavey did not regard it as an emergency in terms of hours, but only in terms of days (J.A. 73-79).

Other Matters. The court made extensive findings with respect to the testimony of Dr. Hawken, an expert medical witness for defendant (J.A. 205).

Unlike Dr. Eavey, who considered tubal repair one of two surgical alternatives in the treatment of an unruptured ectopic, Dr. Hawken stated flatly that this was simply never done in the District of Columbia in 1955, and was not good practice (J.A. 172-174). He never made any point about the year 1955 as such, and testified that as regards repair the situation would be the same in 1955 as it was in 1964 (J.A. 185, 186-187). He expressly disagreed with Dr. Eavey's statement of when re-

pair might be undertaken (J.A. 176, cf. J.A. 40-41). It was not in his hands a real alternative. It was an "unusual" technique as far as he was concerned. (J.A. 177). So also was the colpotomy technique by Dr. Hawken's lights (J.A. 184).

The court denied plaintiff's motion to strike this testimony because its inapplicability to the facts of the case (J.A. 172, 173, 176).

On cross-examination, plaintiff's counsel asked Dr. Hawken to assume the case of "a physician that purported to have this technique as part of his skill, which would preserve the functioning of the tube." But the court would not permit the doctor to answer "because the doctor said that back in 1955 this was not done" and counsel "can't cross-examine on the basis that that statement is wrong" (J.A. 177-178).

A motion to strike for failure of the expert to disclose the reason for his opinion was also denied, the court pointing out that plaintiff's counsel could inquire on this subject in cross-examination (J.A. 181). However, the court refused to allow counsel to cross-examine as to considerations which enter into the decision to repair or not to repair because the physician had already stated that it was "not good practice" to repair (J.A. 182-183, 183-184).

STATEMENT OF POINTS

The court below erred in the following respects:

1. In making findings of fact, and supplemental findings of fact, that were clearly erroneous and irrelevant to the issues.
2. In failing to make proper findings of fact.
3. In excluding evidence which should have been received, and in receiving and considering evidence which should have been excluded.

4. In restricting cross-examination by plaintiff's counsel.
5. In applying an erroneous standard of duty and care to the facts of the case.
6. In applying an erroneous standard of proof to the facts of the case.
7. In entering judgment for defendant.
8. In failing to enter judgment for the plaintiff.

SUMMARY OF ARGUMENT

"This case touches a sensitive and important area of human rights. . . a right which is basic to the perpetuation of the race--the right to have offspring. . ."

Here as in *Skinner v. Oklahoma*, 316 U.S. 535, we deal with an awesome power: the power to sterilize. In the *Skinner* case, the Supreme Court gave effective protection to a convicted felon, against the arbitrary exercise of this power to sterilize, according to the judgment of a court and state legislature. Resolution of this case depends ultimately on giving effective protection to patients in government hospitals, against the arbitrary exercise of the power to sterilize, according to the judgment of a single staff surgeon. Cf. *Application of the President and Directors of Georgetown College*,—U.S. App DC_____, No 2189 decided February 3, 1964, 331 F.2d. 1000 and 1010.

1. The court's finding that repair was not "reasonably possible" assumes that the decision is dictated by medical considerations only. But other important values are involved which make "perusal as an operative risk not enough." The law gives recognition to these values, so that a patient has a right to assume that she will not be sterilized unless there is no alternative, however difficult, that

will preserve the function. A contraceptive motive, voiced by the operating surgeon, is opposed to this standard. Sterilization is not a matter of choice. Most certainly it should not be a matter of choice with the operating surgeon when "reasonable specialists might differ."

2. Whether medical necessity is or is not the only justification for sterilization, the patient has a right to be fully informed.

Here plaintiff was not told of any choice before or after the operation. After the operation, she was not told that a part of the tube remained, making restorative surgery still possible. Consequently, she not only failed to seek help, but actually misled physicians who treated her later. She did not learn that a part of the tube remained until she underwent a complete hysterectomy in 1958. She did not learn that there had been an alternative to repair the tube until the admission was made on deposition in 1960.

The rule followed in most circuits is that withholding of such information prevents the running of limitations under the Federal Tort Claims Act. Likewise, the better reasoned opinions reject the contention that an operation undertaken without a fully informed consent is a prohibited "assault and battery" under the act. It is also negligence.

It is not necessary for plaintiff to carry the impossible burden of proving that restorative surgery would have been effective. It is sufficient to show that failure to consult deprived plaintiff of the right to try it and prove it.

3. Defendants surgeon failed to consult with another physician. Hospital standards applicable throughout the United States recognize that in an operation effecting a sterilization, "We are dealing . . . not only with professional but also moral and legal considerations." Therefore, "No matter how clearly an operative procedure of this

nature may be indicated, it is an accepted principal that two or more physicians should agree before it is carried out." The court erroneously excluded the published standards as hearsay, but more importantly, failed to give recognition to the moral and legal basis which underlies these standards.

ARGUMENT

The many claims of error in this case can, to a large extent, be related to the fundamental legal approach one takes to medical malpractice cases. In the case at bar, the trial court expressly disagreed with the approach of this court in *Goodwin v. Hertzberg*, 91 U.S. App. D.C. 385, 201 F.2d 204. Quoting from *Christie v. Callahan*, 75 U.S. App. D.C. 133, 124 F.2d 825 this court said:

"Malpractice is hard to prove. The physician has all the advantage of position . . . What therefore might be slight evidence where there is no such advantage, as in ordinary negligence cases, takes on greater weight in malpractice suits. . . . Generally speaking, direct and positive testimony to specific acts of negligence is not required. . . ."

The trial court took a very opposite position:

" . . . I think perhaps it should be difficult, for the doctor's protection, because there are many unfounded claims . . .

"I think a good deal of that supposed difficulty is speculative . . .

" . . . I think if it [were] contrary to proper practice . . . I shouldn't think you would have much difficulty getting some specialist to say so." (J.A. 150-151)."

⁹ THE COURT: . . . I had a case of malpractice against a doctor that I tried without a jury just about a year ago which I decided for the plaintiff, and there were two very high-class doctors gave
(Continued on following page)

A defensive attitude toward malpractice charges is easy for lawyers to come by. Despite our criticisms of the medical profession, we are brothers under the skin in our sensitivities about "professional reputation." This value, so important to all of us, can be quickly brought to bear on any situation. This is evident in the number of rulings by the learned trial judge where he explains, "professional reputation is at stake" (J.A. 152, 158, 170, 196, 202).

It is also at the root of many other rulings by the trial court, and many other courts, where this sensitivity to the problems of professional men is not expressed, or even consciously adverted to. It is more often than not masked by a certain affinity for strict construction and technical niceties. (Cf. J.A. 194-195).

In this case, however, much more is at stake than professional reputation. Here we are concerned with the process which caused plaintiff the loss of a fundamental human right, a right which the

(Footnote 9 continued)

testimony as to what was accepted practice, which was entirely different from what the unfortunate well-meaning defendant doctor did in the case.

So these difficulties are no greater than difficulties in any other case. There used to be these difficulties, but I think they don't exist to the same extent, if at all.

MR. DOWDEY: I might say this in connection with that matter. Your Honor, since Your Honor has mentioned an experience, In this case it must be obvious that I have had some very careful medical tutoring and certainly I have consulted with many specialists in this field.

THE COURT: I don't doubt that for a moment.

MR. DOWDEY: However, not a single one of them, although they are close friends of mine, would come in here and testify. They would not even allow me to give their name to my client.

THE COURT: Maybe they wouldn't want to testify because their testimony would not be in accordance with your hopes.

MR. DOWDEY: That is not the situation. (J.A. 195-196).

Supreme Court calls "basic to the perpetuation of the race—the right to have offspring . . . one of the basic civil rights of man." *Skinner v. Oklahoma*, 316 U.S. 535.

It will be fruitful therefore to re-examine the rulings in this case according to a scale of values more concerned with how the power to sterilize is exercised. After all, as the Supreme Court said in the *Skinner* case, from the effects of sterilization "there is no redemption." The victim "is forever deprived of a basic liberty."

1. A Possible Alternative To Sterilization

We can only accept the trial court's conclusion that repair was not "Reasonably Possible" in this case, if we bind ourselves to accept, unquestioningly, the operating surgeon's fiat in the matter.

There are, of course, instances in which the range of decision is so one-sided, that there is no real choice. The operating physician gave an example: "The idea would not be to preserve the present pregnancy involved. This could not be done" (J.A. 53).

But here there was a "question involved . . . her future child-bearing function might be preserved" (J.A. 53). It was an alternative, "where reasonable specialists might differ" (J.A. 58).

If the "question involved" is one "where *reasonable* specialists might differ," how can it be said that repair is not *reasonably* possible?

The trial court, of course, was quick to point out (J.A. 191):

"If this is a matter on which reasonable specialists might differ, standing alone that ought to be a reason for throwing out this case because if a matter is such as to which reasonable specialists might differ, then there can't be negligence to make one choice as against the other."¹⁰

¹⁰ The operation of this rule is a more formidable barricade against professional liability than its gentle reasonableness suggests. The defendant can nearly always find a learned colleague with a glittering reputation to testify that the choice is in an area "where reasonable specialists might differ." In this case it was even possible to find a physician who would not undertake repair under any circumstances, or only in the

(Continued on following page)

But this familiar rule is inapplicable here. It assumes that the decision is dictated by medical considerations only. It makes the decision to sterilize, from which "there is no redemption," a matter of pure medical judgment, decided by a single surgeon.

Other very important values are involved: personal, moral, ethical, religious and emotional:

"You cannot sterilize a patient without profoundly affecting his psyche, even when the procedure is a curative necessity. For this reason a perusal as an operative risk is not enough; you must assess the effect of the operation on his total being. Moreover, in performing a sterilization you are not merely removing a uterus or ligating a vas deferens, you are cutting the cord of future life . . ." ¹¹

Defendant's medical witness disdained such considerations, as did the court (J.A. 182-184). But this is precisely the point that must be decided:

To what extent is the selection of a technique which will destroy the childbearing chances of the patient committed to the personal judgment of an operating surgeon?

All will admit that an operation necessarily involving sterilization may be performed in the name of surgical necessity. A diseased Fallopian tube may be removed to save the life of the patient. But may it be removed for any other purpose? For the greater comfort or convenience of the patient or the elimination of future medical risk?

The law is clear that causes short of necessity do not provide justification. A patient has the right to assume that important parts of his body will not be mutilated (that is, removed or functionally destroyed) unless there is no alternative, however difficult, that will preserve the limb or organ involved.

Note 10 Continued

most unlikely situation. Defendant was able to secure such testimony. Plaintiff was unable to secure an expert to the contrary, nor even to challenge, on cross examination, the expert's failure to take into consideration the alternatives and criteria to which Dr. Eavey admitted.

¹¹ E. Fuller Torrey, "Sterilization: A Problem in Medical Ethics," Vol. 31, No. 1, McGill Medical Journal (February 1962), wherein are collected references to moralists of all faiths.

For example, in *Wells v. Van Nort*, 100 Ohio St. 101, 125 N.E. 910 (1919), a case of malpractice was made out solely on the admission of the physician: "I found her tubes in bad shape, and I removed them. I could have treated them but the chances are that she might have been in the hospital for two or three months; so I thought I had better take them out."

Here Dr. Eavey was opposed to repair:

"... primarily because of her experience up to this point... for if this patient conceives her chances of having another tubal pregnancy are far greater than that of the average population. Average female population." (J.A. 42).

His opinion, repeated by the trial court, was that repair was possible if the tubal pregnancy is "early enough and small enough." Both of these conditions were satisfied by the facts of the case.

"The gestation was of four or five weeks duration." There are "not many found much earlier than that, that's true" (J.A. 43).

It was so "minute" it could not be seen (J.A. 44).

The only consideration voiced by Dr. Eavey which argues against repair, argues against repair in contraceptive terms.

Other Fallopian tube removal cases having some point here are *White v. Hushfield*, 108 Okla 263, 236 P. 406 (1925); *Tabor v. Clifton*, 63 Ga. App. 768. 12 S.E. 2d 137 (1940); *Physicians and Dentists Business Bureau v. Dray*, 8 Wash. 2d 38, 111 P. 2d 568 (1941); *Hundley v. St. Francis Hospital*, _ Cal. App. 2d _, 327 P. 2d 131 (1958). These cases rest in part at least, on well recognized principles of medical ethics:

"A surgeon may have occasion to treat a severe hand injury with extensive damage to tendons and adjacent structures. If there is a possibility that extensive surgical repair may preserve part or all of the hand, the surgeon is bound in con-

science to do all in his power to preserve as much of the hand as possible. Although it would be easier for the surgeon to amputate, he is bound in the name of moral justice to conserve as much tissue as possible."¹²

But even more is involved here:

We are dealing with a matter that has to do, not simply with the individual himself, but with future generations. Therefore the law and medical ethics have always regarded the right of procreation as sacred. Operations which interfere with procreation--abortions and sterilizations--are subject to restrictive safeguards that do not ordinarily attach even to the amputation of an arm or a leg, for example.

"The same public policy that underlies laws to prevent criminal abortion applies to operations that produce sterility, even though that policy is not written in statutes specifically forbidding such operations. . . ."¹³

The American Medical Association and other leading authorities on this subject hold that there is no distinction morally and legally between abortions and sterilization, that the only justification for either is necessity.

¹² Bernard J. Ficarra, M.D., *Newer Ethical Problems in Medicine and Surgery*, Westminster, 1951, pp. 15-16.

¹³ *Ibid.* at p.21. See also Norman St. John Stevas, *Life, Death and the Law, a Study of the Relationship Between Law and Christian Morals in the English and American Legal Systems*, London, 1961.

Unnecessary sterilizations are considered one of the major excesses of modern medicine. Louissell and Williams, *Trial of Medical Malpractice Cases*. Bender, 1960, §19.11.

Thus, a specific request for sterilization is insufficient authority; there must also be medical necessity.¹⁴

It is not and cannot be a matter of choice. Most certainly it should not be a matter of choice which is left solely to the judgment of a surgeon when "reasonable specialists might differ" about the matter.

2. Inadequate Consultation with Patient

The conversations plaintiff had with her physician both before and after the operation were true and accurate--as far as they went. It is what plaintiff was not told that is misleading.

She was not told before the operation that a decision might be made where the preservation of her childbearing function would be weighed against the risk of future ectopic pregnancies.

She was not told after the operation that such a decision had been made for her.

She was not told after the operation that there was still a chance of saving her childbearing function: that only part of the tube had been removed, and restorative procedures were available.

It is possible to consider this case from this single point of view. All the physicians admitted to the possibility of restorative surgery. The only difference was when restorative surgery should be undertaken--at the time of the original operation, or later.

But the court's rulings on these matters were even more terse than the physician's consultations with his patient. Part of what he

¹⁴ "Medico-Legal Aspects of Sterilization, Artificial Insemination and Abortion," by Edwin J. Holman of the Law Department of the American Medical Association (1954), revised and republished in Vol. 166 (1958). The legal view parallels traditional moralists of all faiths, see note 11, supra.

said to his patient was considered, but the Court refused to consider the inadequacy of what was said. We end, therefore, with findings that are half-truths. Like the physician's explanations to his patient, the findings of the court mislead by what they do not say, and what the court would not hear.

Part of the reason for this, like the strict construction of the physician's testimony, depends on a narrow reading of the broadly phrased pre-trial order.

But if such strained readings are ever in order in modern pleading, they are certainly not in order to prevent an inquiry into the candor shown by a physician to his patient about a sensitive subject like sterilization.

After all, if there is ever any reason for an unnecessary sterilization, it must depend entirely upon the fully informed consent of the patient.

The general obligation of a physician to fully inform his patient of all major choices affecting his health is nowhere more important than where the choice involves sterilization. If there is any possible exception to the rule dispensing with medical necessity in such cases, it depends on a very deliberate choice by the patient based on a full explanation.¹⁵

¹⁵ Some modern innovators who would dispense with the rule of necessity, (discussed *supra*, N. 14), do so in the name of greater freedom of choice by the patient:

"The idea that sterilization to prevent conception is not a matter for individual control denies exactly what we have been pleading, that moral responsibility requires such choices to be personal decisions rather than natural necessities."

Joseph Fletcher, *Morals and Medicine*, Princeton, 1954, noted by Torrey, *supra*, N. 11.

It might seem at first that the newer ethical view finds support in the frequency with which courts dealing with unnecessary sterilizations remark that the procedure was not specifically authorized by the patient. Actually, the basis is entirely different. The cooperating victim of a criminal abortion, for example, although not within the statutory prohibition herself, nevertheless bases her claim for malpractice on an immoral contract or transaction. *Hunter v. Wheate*, 53 App. D. C. 206.

Other matters that arise in respect to the failure to fully inform the patient, are purely technical, and while some once had a certain vitality, it has now become plain that they have been laid at rest.

The first proposition, that because of the failure to fully inform the patient, the operation becomes an assault and battery excluded by the Tort Claims Act, was flatly rejected by the trial court. The 8th Circuit in *Moos v. U.S.*, 225 F.2d 705, once held that an unauthorized operation was an assault and battery excluded by the act relying on *Bonner v. Moran*, 75 U.S. App. D.C. 156, 126 F.2d 121. But the description in *Bonner* was simply to the effect that an unauthorized operation was a "technical" battery. This does not prevent it from being negligence, as well, *McClees v. Cohen*, 158 Md. 60, 148 A. 124, *Physicians and Dentists Bureau v. Dray*, 8 Wash. 2d 38, 111 P. 2d 568. Chief Judge Hoffman of the Eastern District of Virginia expressly stated that *Moos v. U.S.* was wrongly decided and discussed the matter at length in a very scholarly opinion, *Lane v. U.S.*, 255 F. Supp. 850.

The twin objections that failure to inform, or misleading a patient, is the prohibited form of "misrepresentation" under the act, and that limitations under that act are not tolled thereby has likewise been repudiated in most circuits that have considered the matter, *Quinton v. U.S.*, 304 F.2d 234 (C.A. 5, 1962). *Hungerford v. U.S.*, 192 F. Supp. 581, originally relied upon by defendant in this case, has since been reversed, 307 F.2d 99 (C.A. 9, 1962). The 2nd Circuit has now joined the 5th and 9th in *Kossick v. U.S.*, 330 F.2d 933, decided April 1964, expressly repudiating the 1st Circuit's *Tessier v. U.S.*, 269 F.2d 305. The speciousness of the "misrepresentation" label can be seen also in *U.S. v. Neustadt*, 366 U.S. 696.¹⁶

¹⁶ "So far as misrepresentation has been treated as giving rise in and of itself to a distinct cause of action in tort, it has been identified with the common law action of deceit," and has been confined "very largely to the invasion of interests of a financial or commercial character, in the course of business dealings." (p. 711. N.26).

Causation. The failure of the court to inquire into the fulsomeness of the physician's explanations to his patient after the operation was assertedly immaterial in any event, because there was no proof that had she been fully informed, her childbearing function could have been preserved.

But this is not the test. If it were, it would be impossible to meet, and the very wrong which prevents proof would have its own built-in immunity. The point is clearly elucidated by the following colloquy with the court (J.A. 191-193).

MR. DOWDEY: . . . Restatement of Torts, §432. If the matter would have happened even if the duty had been performed, then the defendant is not liable; but if the injury might have been caused by a breach of duty or by an independent cause, there is liability for the breach.

The classic case, which I'm sure your Honor is familiar with, is the case of the two hunters who both fired a shotgun in the same direction and a man was killed. Both were held liable because, while they couldn't establish which one hit him, nevertheless they couldn't prove that their shot did not strike him.

THE COURT: Well, I don't think either one of them could be convicted of a homicide.

MR. DOWDEY: Not of homicide, but of tort liability.

THE COURT: I'm not sure whether that case is good law . . . It is an example that is used sometimes, but I am not so sure it is good law. I think a person, to recover damages, would have to show whose gun caused the death. I certainly

would be inclined so to hold if I was trying an action for damages here.

MR. DOWDEY: Well, in the instant case I think this principle is followed in the District of Columbia in such cases as *Kendall v. Gore Properties*. [98 U.S. App. D.C. 378, 236 F.2d 673]

That was where the house painter was hired without an adequate investigation.

THE COURT: Oh yes.

MR. DOWDEY: And the Court of Appeals pointed out that it is true enough that even if they had an adequate investigation the woman might still have been assaulted, but, on the other hand, the purpose of the investigation would be to prevent this sort of thing.

THE COURT: That case involved a question of proximate cause.

MR. DOWDEY: Yes. Well, I think that is what we are talking about at this moment. For example, there is a certain analogy here, if I may point it out:

"To say that appellees may fail to make even the most cursory inquiry and then be allowed to excuse themselves in their ignorance is to say that their recklessness will be exalted."

And I would submit, Your Honor, that we are in precisely the same situation here as regards consultation.

3. No Consultation with other physicians

The foregoing colloquy with the court was actually concerned with the lack of a consultation with other physicians. The interchangeability of the language, heightens the point.¹⁷ The physician in this case under-

¹⁷ See also, The American Medical Association's Principles of Medical Ethics (1949), Article III on Consultations. It gives special attention to the duty of being candid with the patient (or a relative or friend), about consultations. Article III, § 2 and § 7. (J.A. 95)

took the sterilization with no surer guide than his own personal opinion, or predilections in the matter, as you may have it.

The court excluded all published standards as to requirements of consultations with other physicians: the AMA principles of medical ethics and the more specific standards of the Joint Commission on Accreditation of Hospitals. These later standards are represented as being followed by practically all of the hospitals in the District of Columbia (J.A. 83-86).

Because the standards are published in a book, the court apparently thought that the same rule applicable to textbooks was involved, which would exclude them as hearsay (J.A. 126-136, 148, Cf. JA 146-147).

But they are not hearsay, they are the published rules. Violation of them, like violation of any other published rule or representation, is of itself evidence of negligence. See cases collected in *Sanzari v. Rosenfeld*, 34 NJ 128, 167 A2d 625, 630; *Stone v. Proctor*, ___ N.C. ___, 131 SE2d 297 (American Psychiatric Assn. Standards) and Cf. *Rollerson v. U.S.*, ___ U.S. App. DC ___, No. 17675, dec'd Oct. 1, 1964; and *Wigmore on Evidence*, 3d Ed, §1690 illustrating the very narrow limits of the policy excluding "learned treatises" as hearsay.

It is evident from the writings about these standards, that the obligation to consult where sterilization is involved does not depend on medical criteria alone.

"No matter how clearly an operative procedure of this nature may be indicated, it is an accepted principal that two or more physicians should agree before it is carried out. We are dealing here with not only professional but also moral and legal considerations" (J.A. 94).

CONCLUSION

Shortly before she underwent a total hysterectomy, plaintiff consulted a civilian physician near a Florida airbase. He was so certain of his diagnosis of a miscarriage, that he wrote the U.S. Attorney in this case indicating that Mrs. Harvey is emotionally disturbed because she insisted that she had been sterilized.

Confronted with this, Dr. Eavey was still not prepared to admit that miscarriages occurred. He says he has "no way of knowing how certain either of these physicians were of their diagnosis . . . I have no way of knowing what conclusive evidence either physician had." (J.A. 48)

We may very well say, therefore, that had he been a little less certain of his own personal judgment, and repaired rather than amputated, plaintiff might have a family today.

Had he been a little less certain of his own personal judgment and consulted with her, before or after the operation, she might have a family today.

Had he been a little less certain of his own personal judgment and consulted another physician, she might have a family today.

These points do not depend on medical criteria or the subtleties of gynecological surgery. The facts are essentially undisputed. All of the necessary expertise in this case comes from a most impeccable source: the operating surgeon. Indeed, it is his own testimony that poses the questions.

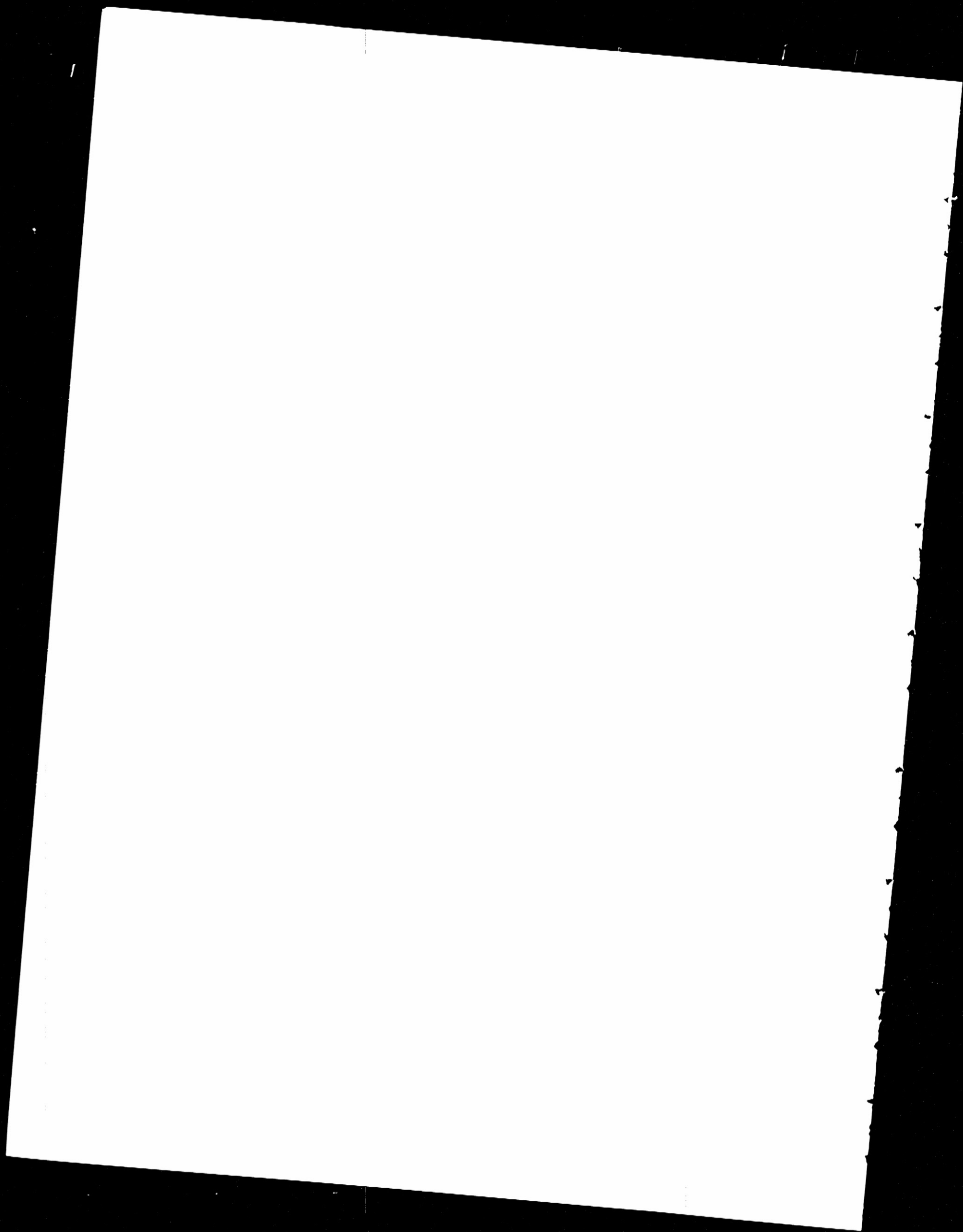
How much protection does the law give to the basic liberty of procreation? Who can take it away? What are the procedures? Who decides that a sterilizing operation is going to be performed, absent, of course, emergency conditions? Who decides that restorative surgery will not be tried?

The facts being essentially undisputed, this court can resolve the basic questions on this record, considering so much of the excluded evidence as necessary. Cf. Williams v. U.S. ____ US App. D.C. ____, No. 18462, dec'd Oct 1, 1964, page 5-6. In this event, the case should be remanded with directions to enter judgment for the plaintiff and fix the amount of damages. If on the other hand, this court is of the opinion that other things should be considered, a new trial would be in order.

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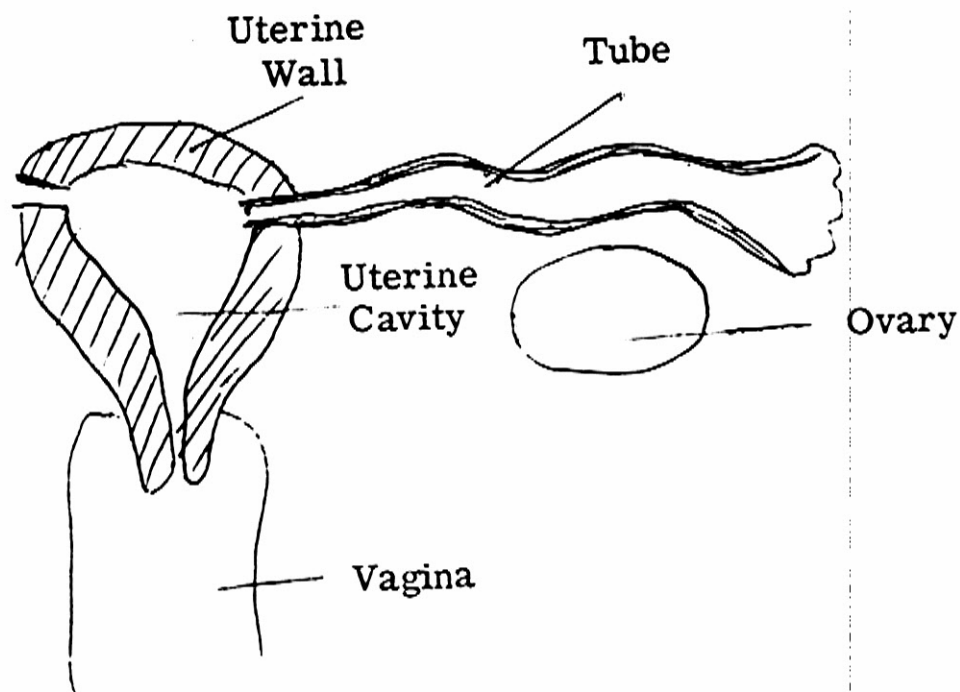


ANATOMY AND MEDICAL GLOSSARY

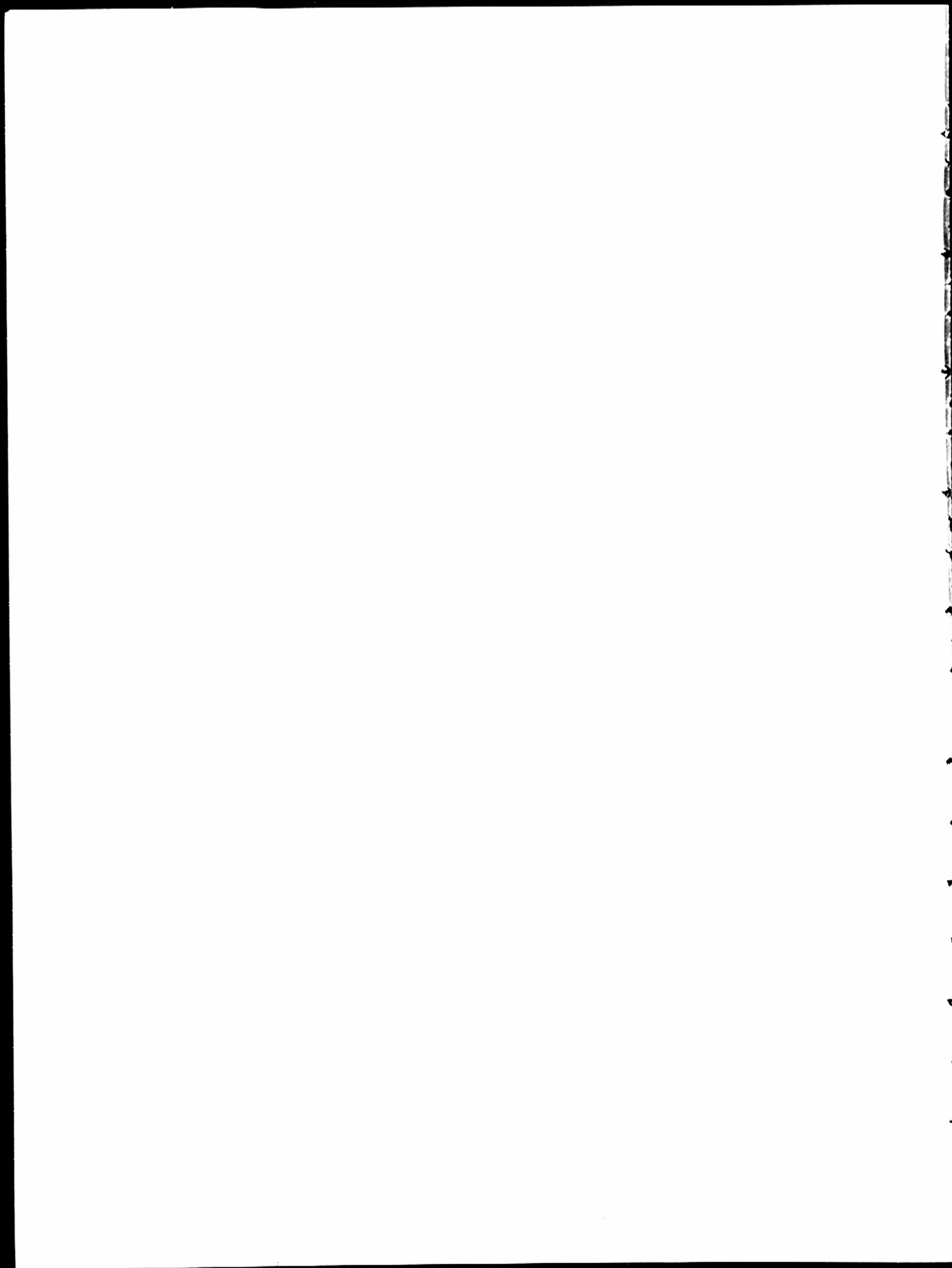
(From deposition of government physician, Dr. Eavey)

An *ectopic pregnancy* is one which attaches itself outside the uterus (uterine or endometrial cavity). Although ectopic precisely signifies a pregnancy anywhere outside the uterus, it usually signifies the most common type which is a pregnancy in one of the Fallopian tubes (*tubal pregnancy*) (J.A. 44-45).

Dr. Eavey has made a schematic drawing which shows a front view of the female reproductive organs involved (Exhibit C to deposition, J.A. 26-27, 66).



The tube is about 3 inches long (J.A. 31-32). The tube and the ovary together are known as the "*adnexa*," being "*adnexed*" to the uterus (J.A. 41). The place where the tube enters the uterus is called the "*Isthmus*." The other wider end of the tube is called the "*fimbriated end*." The

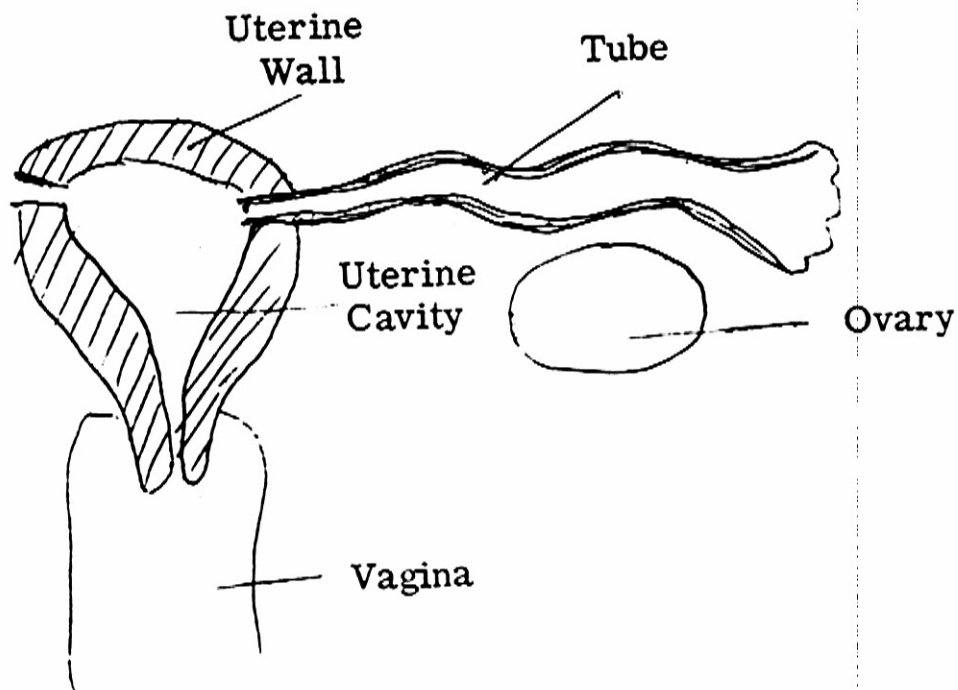


ANATOMY AND MEDICAL GLOSSARY

(From deposition of government physician, Dr. Eavey)

An *ectopic pregnancy* is one which attaches itself outside the uterus (uterine or endometrial cavity). Although ectopic precisely signifies a pregnancy anywhere outside the uterus, it usually signifies the most common type which is a pregnancy in one of the Fallopian tubes (*tubal pregnancy*) (J.A. 44-45).

Dr. Eavey has made a schematic drawing which shows a front view of the female reproductive organs involved (Exhibit C to deposition, J.A. 26-27, 66).



The tube is about 3 inches long (J.A. 31-32). The tube and the ovary together are known as the "*adnexa*," being "*adnexed*" to the uterus (J.A. 41). The place where the tube enters the uterus is called the "*Isthmus*." The other wider end of the tube is called the "*fimbriated end*." The

third of the tube closest to the fimbriated end is called the "*ampullary end*" (J.A. 26-27).

In the ordinary course of events, the female ovary emits an egg about once a month. It descends through the Fallopian tube where it may be fertilized by the male sperm. Then it travels to the uterine cavity where it attaches itself and is nourished until it comes to term and is delivered. A tubal pregnancy occurs where the fertilized egg, instead of descending to the uterus and attaching itself there, attaches itself instead to the wall of the Fallopian tube. As it grows, it presses against the wall of the tube until the tube ruptures or the pregnancy is aborted.

The chief danger in a tubal pregnancy is hemorrhage and all the serious consequences that result from hemorrhage. Therefore, *tubal pregnancies are classified according to the amount of bleeding involved*, little attention being paid to whether the bleeding is the consequence of rupture or abortion (J.A. 16-17, 44-45).

A *ruptured tubal pregnancy*, therefore, includes "both strict rupture and the tubal abortion in which there is considerable hemorrhage into the abdominal cavity . . . The amount of bleeding is really, in the final analysis, the important thing" (J.A. 17).

Correspondingly, where there is "a very small amount of ooze of blood out of the end of the tube, this perhaps might be classified as unruptured and yet really it is an early or beginning tubal abortion" (J.A. 16). *Unruptured tubal pregnancies*, therefore, are "those in which the tubal pregnancy [is] still intact, or at most with the very earliest of beginnings of tubal abortions" (J.A. 17).

A ruptured ectopic pregnancy is usually a very grim and dangerous experience for a patient. The heavy bleeding produces severe symptoms, pain and debility. It is almost invariably an acute emergency condition (J.A. 16, 55-56).

Because of the amount of bleeding involved, a ruptured ectopic pregnancy is "a relatively easy diagnosis." On the other hand, an early rupture, or an unruptured ectopic, is a very difficult diagnosis because the symptoms are mild and resemble, so many other things (J.A. 16-17, 39, 43, 53).

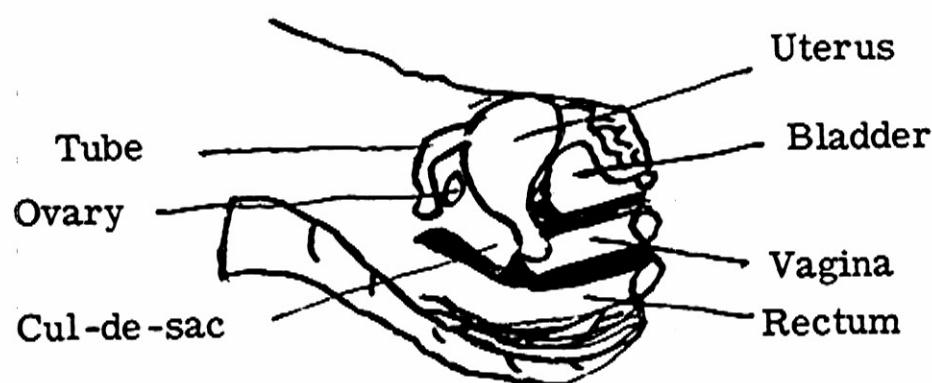
Therefore, "*diagnosis of a tubal unruptured pregnancy is a relatively uncommon thing*" (J.A. 17). Many, and perhaps most tubal pregnancies rupture or abort with little or no bleeding, but these seldom come to the attention of a physician. The "overwhelming majority of tubal pregnancies when diagnosed have ruptured" (J.A. 13).

Throughout his entire training, internship, and residence at University Hospital in Baltimore, Dr. Eavey never once saw an unruptured ectopic (J.A. 13-16). The first and only place he had ever seen an unruptured ectopic was at Bolling. There he worked, not under supervision, but on his own. (J.A. 13-14).

"The unruptured tubal pregnancy can be diagnosed really only by visualizing it, and this must be done through a colpotomy or with the use of colposcope, or through exploratory laparotomy" (J.A. 17-18).

The diagnostic operation chosen by Dr. Eavey was *colpotomy*. This involves "an incision in the upper end of the vaginal vault, into the cul-de-sac of Douglas and thereby establishing presence or absence of blood, and in many instances being able to visualize the structures of the pelvis including the tubes and ovaries" (J.A. 19).

Dr. Eavey drew a lateral view of the female pelvic region, indicating graphically the anatomy involved and the location of the colpotomy incision (J.A. 21-24, 66).



The incision made is about 4 cm. in length. It is much easier on the patient than ordinary abdominal surgery done by laparotomy (J.A. 19-24, 51). However, it is not commonly used by general surgeons. It is useful for treatment only by persons specially trained in the technique (J.A. 21-22, 54-55).

In the instant case, Mrs. Harvey was placed under a general anesthetic. A surgical incision, colpotomy, was made. The patient's right Fallopian tube was examined through this vaginal incision. According to the operating report:

"A small unruptured tubal pregnancy [was found] with a small amount of blood coming from the fimbriated end of the tube."

In his deposition, Dr. Eavey was more specific (J.A. 29):

"The small pregnancy [was] noted in the ampullary portion [outer third, J.A. 27] distal portion would be right, of the right tube with a small amount of blood oozing from the fimbriated end of the tube."

Repair. The location of the pregnancy is extremely important, since, as we shall see, its location in the end farthest from the uterus makes it easiest to repair. The actual location can be seen in the diagram drawn by Dr. Eavey as Exhibit "D" to his deposition.

Where, as here, the damage is in the ampullary or outer end, little more is required than cutting, or circumcising the involved tissue, and

pinning it back in place. When the occlusion or defect in the tube is the consequence of a tubal pregnancy, the surgical corrective procedure is only slightly different than when the occlusion appears in some other fashion. Dr. Eavey explains:

[The procedure] depends on where the disturbance in the fallopian tube is, but all of them boil down to re-establishing potency of that tube. It may be a simple matter of circumcising the end of the tube, if most of the tube is healthy except its outer end, which has been clubbed and closed. By circumcising, I mean simply cutting it off and simply pinning the edge of the mucosa back. If the obstruction is in the isthmus portion of the tube the usual type procedure is to incise the tube distal to the obstruction, creating a window in the myometrium (the wall of the uterus), and tuck the freed outer portion of the tube in such a manner that it is now proximal and fits into this window in the uterus. In cases where tubes are nonexistent the procedure has been utilized wherein the ovary is literally buried into the wall of the uterus in such a manner that the one surface of the ovary protrudes into the uterine cavity.

There are times where, if a tubal pregnancy is in the judgment of the operating surgeon considered to be early enough and small enough, that an incision can be made over the pregnancy, the pregnancy shelled out of the tube, and the tube reclosed. This obviously is slightly different in its plastic connotation than are the procedures which are designed to correct an occlusion appearing in another fashion (J.A. 40-41).

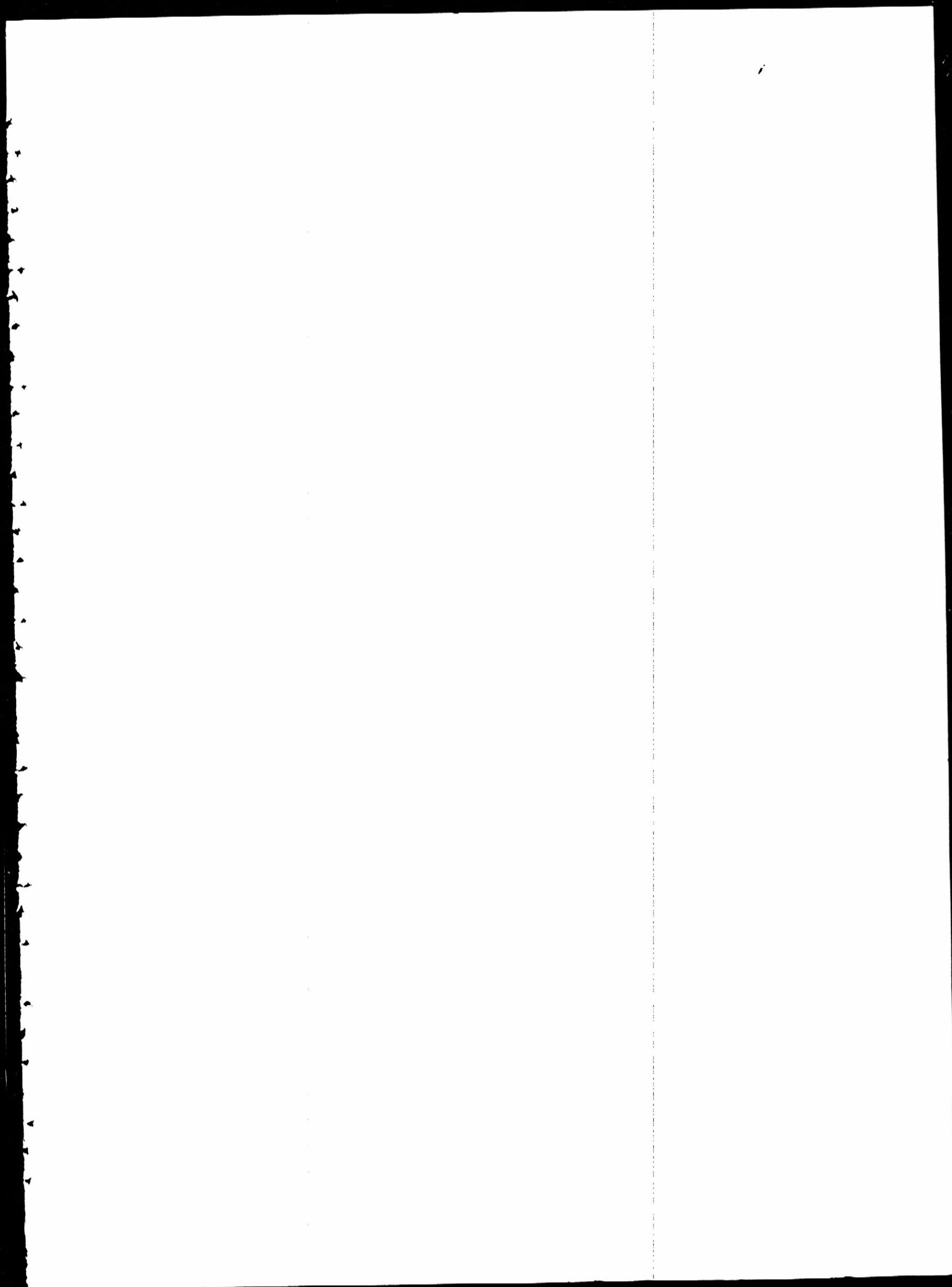
Q. When a woman has a tubal pregnancy what alternative does the doctor have in respect to how he goes about treating her? Are there any?

A. If he establishes such a diagnosis, the only course open is surgical, in most instances requiring the excision of the fallopian tube, partial or total, or as previously mentioned in testimony, the circumstances where the pregnancy may be shelled out of the tube and the tube allowed to remain as a possibly functioning structure (J.A. 54).

Amputation. Dr. Eavey, observing what he claims was an unruptured ectopic pregnancy chose to amputate. He clamped and tied off the tube at its mid-section. He then removed the end farthest from the uterus constituting about one-half the tube (J.A. 29).

All of this was done through the colpotomy incision. Amputation of the tube through the colpotomy incision is a novel technique. The usual procedure upon discovering an ectopic pregnancy is to sew up the incision and complete the operation by laparotomy, that is, an incision through the abdominal wall (J.A. 55, 69). Certainly this is necessary if the situation is a true emergency, or if any substantial bleeding or other technical problem is anticipated (J.A. 20-21). Also, more extensive surgical techniques such as tubal repair, cannot conveniently be done through a colpotomy incision (J.A. 54-55).

After completing the amputation, Dr. Eavey closed the colpotomy incision and did a curettage of the uterus (J.A. 29).



BRIEF FOR APPELLEE

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 18,823

GEORGIANA HARVEY, APPELLANT

v.

UNITED STATES OF AMERICA, APPELLEE

**Appeal from the United States District Court
for the District of Columbia**

United States Court of Appeals
for the District of Columbia Circuit

FILED JAN 15 1965

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QUESTION PRESENTED

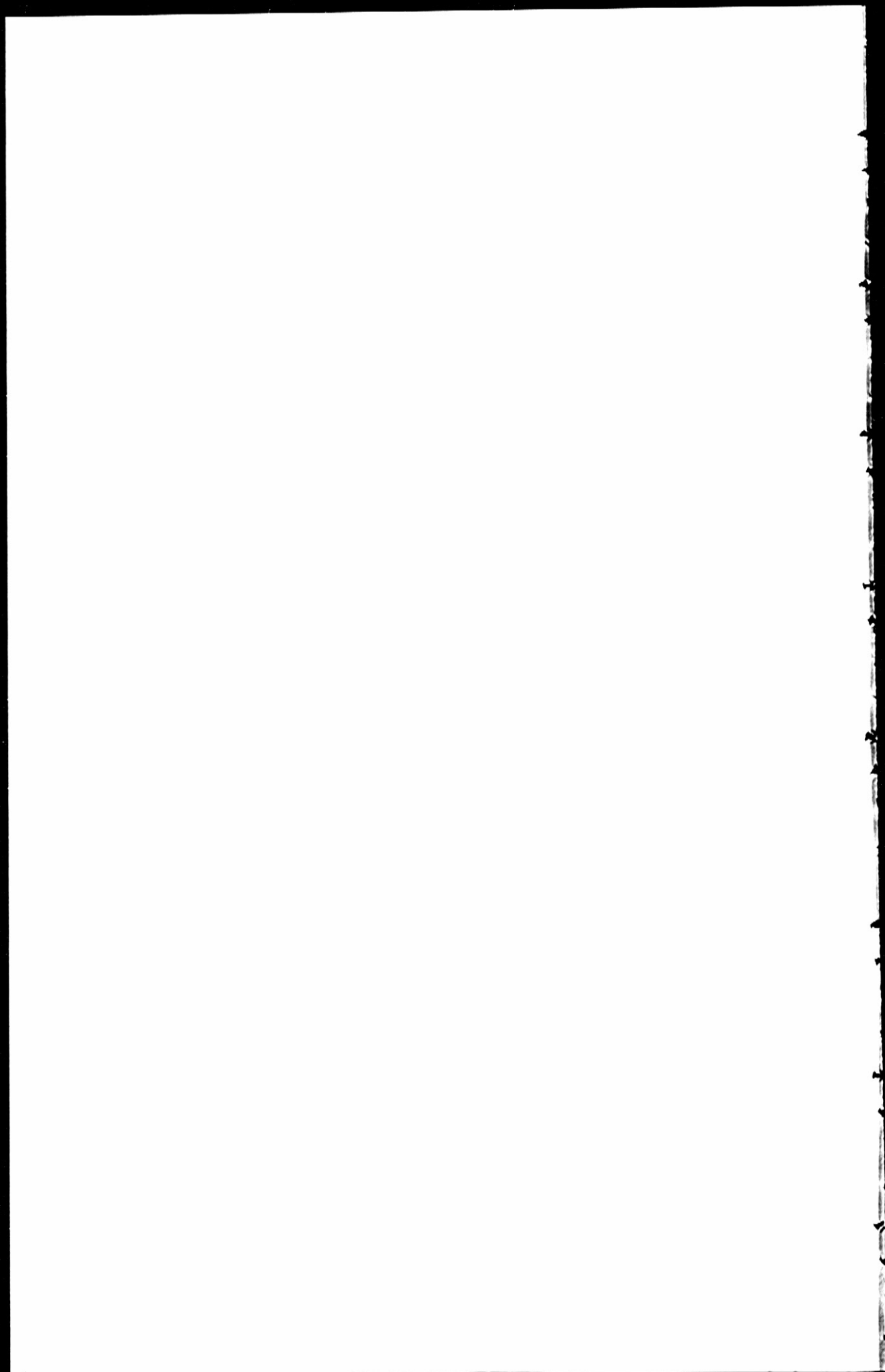
Appellant was operated on for a tubal pregnancy. The pregnancy and a portion of the fallopian tube were removed. She brought suit under the Federal Tort Claims Act, contending that the doctor in question was negligent in not having "repaired" the tube, rather than removing its damaged portion. The District Court heard both parties on the merits, made findings of fact and conclusions of law, and entered judgment for appellee. The question is whether the court's findings were clearly erroneous, such as to entitle appellant to a judgment on the merits.

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GEORGIANA HARVEY, APPELLANT

v.

UNITED STATES OF AMERICA, APPELLEE

**Appeal from the United States District Court
for the District of Columbia**

BRIEF FOR APPELLEE

COUNTERSTATEMENT OF THE CASE

This is an appeal from a judgment for the government entered by the District Court (Holtzoff, J.) after trial. The suit involves a claim of medical malpractice under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2674). The background facts may be summarized as follows:

On February 15, 1955 appellant, then the wife of an Air Force officer, was operated upon at the Bolling Air Force Base Hospital in the District. She arrived there before noon (J.A. 159), complaining of symptoms indicative of a tubal pregnancy and underwent surgery at 3 P.M.

(J.A. 61). The operation consisted of the removal of a tubal (or ectopic) pregnancy and involved at the same time the excision of the damaged portion of appellant's remaining fallopian tube—the other tube having been removed at some previous time as a result of an earlier tubal pregnancy.

Apart from the question whether the suit, filed in 1959, was barred by the two year statute of limitations (28 U.S.C. 2401(b)) this appeal involves contentions that the trial court's findings were clearly erroneous with regard to:

- A. an alleged failure to repair the tube, such that future pregnancy might be possible;
- B. an alleged failure properly to consult with appellant and
- C. an alleged failure to consult with other physicians prior to removal of the tube.

A. Alleged Failure to Repair Tube

Appellant's case as to the availability of repair rests solely upon alleged admissions in the deposition of Doctor Eavey, the obstetrician-gynecologist who performed the operation at bar. The doctor stated that in his judgment, at the time in question, repair of the tube was not a possibility and not warranted (J.A. 41, 53). When asked whether certain repairative techniques "are" "relevant to this case", Doctor Eavey answered;

"There are times where, if a tubal pregnancy is in the judgment of the operating surgeon considered to be early enough and small enough, that an incision can be made over the pregnancy, the pregnancy shelled out of the tube, and the tube re-closed" (J.A. 40-41).

The pregnancy involved in this case was of four or five weeks duration, and the Doctor stated that not many pregnancies are found at an earlier stage (J.A. 43). Dr. Eavey then went on to explain that it would have been practically impossible to repair in a situation where, al-

though the pregnancy might be sufficiently early, the tube itself had been markedly distorted and damaged as in the case of appellant (J.A. 41-42).

At the conclusion of the deposition, Doctor Eavey was asked whether he would regard it as incredible if someone else disagreed with him as to the possibility of repair to the tube. He answered "I never regard it as incredible if anyone disagrees with my judgment" (J.A. 58). The following then occurred:

"Q. You admit the possibility of someone equally skilled concluding otherwise?

MR. HANNON: Same objection. The Doctor has no way of judging what any other doctor has judged in the same circumstances at this time.

A. I think what Mr. Hannon says is true, I have no way of knowing that.

Q. If someone else had, would you regard it as negligent?

A. No more than if someone would regard me as negligent.

Q. It is in the area of judgment, in your opinion?

A. Yes, sir.

Q. Where reasonable specialists in the field might differ?

A. True." (J.A. 58).

The government produced a medical witness, Doctor Stafford Hawken, an expert obstetrician-gynecologist, who was the physician available for consultation at the time of the operation at bar (J.A. 34-35). Dr. Hawken testified that in 1955 in the District of Columbia it was not acceptable medical practice to attempt to repair a fallopian tube in the circumstances of this case (J.A. 172). Further Doctor Hawken stated that the procedure followed by Doctor Eavey in this case was in accord with good medical practice, and that an attempt to repair would not so accord (J.A. 174). Within the knowledge of Doctor Hawken, there were no physicians in the District in 1955 who would have followed a repair procedure (J.A. 177).

In discussing the alleged alternative of repair, Doctor Hawken said

"Repairative procedures on tubes—everybody, as far as an obstetrician or gynecologist, is anxious to preserve the function of the female as much as possible, but when he is faced with a situation such as an ectopic pregnancy, as I tried to say before, his idea is to remove the pathologic tissue and get out of there because these patients may be into trouble. It would depend upon the individual patient." (J.A. 185).

By "trouble" the Doctor meant death (J.A. 185). If a tubal pregnancy ruptures, the situation can be "extremely serious", the prime danger arising out of hemorrhage (J.A. 20, 44). In Doctor Hawken's opinion, repair would have been considered possible only if the pregnancy were known to be dead (J.A. 174, 176-177, 182), in which case there would be no further active bleeding (J.A. 177). In this case the surgeon discovered some blood oozing from the end of the tube which he removed (J.A. 29).

B. Alleged Improper Consultation with Appellant

This contention encompasses two theories: first that prior to the operation the doctor should have advised appellant as to a repair alternative, and second that after the operation she should have been advised as to the alleged possibility of restoring fertility to the portion of the tube remaining. As to the first contention, the court ruled that the doctor violated no duty since there was no evidence that repair was a reasonable surgical alternative under the circumstances of this case (J.A. 208-209). As to the second contention the court ruled that it had not been raised by the complaint, opening statement, or pre-trial order and thus could not be asserted at trial (J.A. 186-188, 208). Apart from the timeliness of the contention, the court ruled that appellant had failed to prove that advice as to subsequent repair would have produced any different result, noting that there was no evidence to

show that subsequent repair was possible in this case. Further, the court ruled that appellant had not shown that District medical practice in 1955 required advice as to alleged post-operative repair (J.A. 208-209).

Appellant testified that she had not been advised as to the alleged possibility of repair, either before or after the operation (J.A. 164-165). Doctor Eavey stated that prior to the operation he had not discussed a possibility of repair, explaining that this would have held out hope and constituted "unfair optimism" (J.A. 42-43). As to post-operative consultation the Doctor said that he "may" have told appellant of the possibility of plastic repair, however he "likely" discouraged the possibility because appellant's chances of having another tubal pregnancy were "far greater" than average (J.A. 42). Doctor Hawken explained that generally a post-operative attempt to repair the remainder of a tube might have a five or ten percent chance of success (J.A. 186).

C. Alleged Failure to Consult with Other Physicians

Doctor Eavey did not consult with any other physicians prior to the operation at bar. The "specified civilian consultant" available for formal or informal consultation at any time as of 1955 was Doctor Hawken, (J.A. 34-35) who, as noted, testified in substance that there was no departure from accepted medical standards in this case, and that to have attempted repair of the tube, as a surgical alternative, would not have accorded with sound medical practice.

SUMMARY OF ARGUMENT

Pretermittting the question of the Statute of Limitations, the court correctly ruled in favor of appellee on the merits of the case. There was simply no evidence to support the theory that an obstrician-gynecologist, upon diagnosing a tubal pregnancy under the circumstances here present, should have undertaken to repair the fallo-

pian tube rather than partially removing it. In fact there was abundant evidence showing that what was done here was entirely consistent with accepted medical practice and that indeed to have followed a "repair" procedure would itself have been a departure from sound practice. As to the claim that appellee's doctor should have advised appellant as to the possibility of post-operative repair, the court correctly ruled that this was a new theory of liability never before enunciated in the long background of this case and not embraced by the pretrial order. The court also ruled on the merits of the new theory, correctly holding that there was a dearth of evidence to establish that such repair would have been possible in appellant's case. In any event, there was evidence tending to show that appellee's doctor had given the patient such advice.

Introduction

The operation at bar occurred in 1955; the complaint was not filed until 1959. Hence the complaint is, on its face, barred by the applicable two year statute of limitations (28 U.S.C. 2401(b)). At trial, appellant sought to avoid the statute by reliance upon the "date of discovery" rule whereby the cause of action is regarded as not accruing until the claimant knows or should have known of the tortious acts (J.A. 114-116).

We recognize that there is a conflict in the circuits as to whether a cause of action for malpractice under the Federal Tort Claims Act accrues at the time of the alleged improper act or at the time of discovery. Compare *Tessier v. United States*, 269 F.2d 305 (C.A. 1, 1959) (date of act) with *Quinton v. United States*, 304 F.2d 234 (C.A. 5, 1962) (date of discovery) and *Hungerford v. United States*, 307 F.2d 99 (C.A. 9, 1962) (date of discovery). Similarly the circuits are divided on the question whether the issue is to be resolved by reference to state or federal law. *Tessier* looks to state law; *Quinton* and *Hungerford* to federal law. See also *Kossick v. United*

States, 330 F.2d 933 (C.A. 2, 1964) refusing to apply state law in a related area.¹

In our view, however, this Court need not reach the argument because this case was not dismissed on the limitations ground; instead the court elected to hear the merits and entered judgment thereon. Secondly, the record is such that appellant could not prevail under either theory of accrual—date of act or date of discovery. As the trial court ruled, there is no evidence of any “discovery” subsequent to 1955 which could be regarded as the accrual of a cause of action. (J.A. 206) At trial, appellant’s counsel argued that the cause accrued in 1960 when he took the deposition of the doctor who performed the operation (J.A. 110, 116). This position is without merit. As we show, there was nothing in the doctor’s deposition upon which to predicate a malpractice action. Moreover a cause of action must accrue at sometime prior to the filing of suit; otherwise a plaintiff could sue at any time, claiming that upon pretrial discovery or trial itself it would appear that the relevant facts had just been discovered. Hence to accept appellant’s version of the “date of discovery” rule is to abolish any period of limitations. In this case the “discovery” was concurrent with the date of operation; as appellant admitted, she knew after the operation that her tube had been removed and that she could not bear children (J.A. 162, 164, 168). Nothing further was discovered at any subsequent date; hence the case is not one where some particular subsequent occurrence—such as the finding of a sponge in a surgical wound—can be viewed as acquainting the claimant with the existence of a cause of action.

Should this Court determine to resolve the case through the vehicle of the Statute of Limitations, it is respectfully submitted that the appeal be dismissed under any view of that statute.

¹ The authorities are reviewed in Gottlieb and Young, “Medical Malpractice and Limitations under the Federal Tort Claims Act”. 13 Defense Law Journal 257 (1964).

ARGUMENT

The court correctly entered a judgment for appellee on the merits.

A. Alleged failure to repair tube

The plaintiff's burden in a malpractice action is to show by a preponderance of the evidence that the particular physician did not exercise "that degree of care and skill ordinarily exercised by the profession in his own or similar localities." *Quick v. Thurston*, 110 U.S. App. D.C. 169, 171, 290 F.2d 360 (1961) (en banc). In the instant case, as the court below ruled, there was no evidence that Doctor Eavey departed from accepted medical standards. There was simply no evidence to support the theory that upon being confronted with a tubal pregnancy in the circumstances of this case, the Doctor should somehow have undertaken to remove the pregnancy and yet repair the fallopian tube. Moreover since the court elected to hear both parties on the merits, there was abundant testimony from Doctor Hawken, an expert whose qualifications are unquestioned, to the effect that Doctor Eavey's actions were in precise accord with sound practice, and that indeed to have proceeded in accordance with appellant's theories would itself have been a departure from the proper standard. (J.A. 172, 174). Doctor Hawken stated flatly that there were in the District in 1955 no physicians who would have undertaken repairative procedure (J.A. 177); this testimony was absolutely uncontradicted. Thus under the circumstances it is clear that as to the "repair" aspect of the case, the judgment was eminently correct.²

² Cases cited by appellant (Br. p. 22) all deal with situations where a fallopian tube was removed in the course of performing some other unrelated operation. None of the cases involve the existence of tubal pregnancy, a disease of the tube itself. Significantly appellant cites no case holding a physician liable for removal of a tube in the circumstances of this case; nor have we discovered any such decision.

Appellant rests upon that portion of the Eavey deposition wherein the Doctor is said to have admitted that reasonable specialists in the field might have differed over whether or not to attempt repair (J.A. 58). But this testimony cannot entitle appellant to a judgment as a matter of law. The doctor merely recognized the possibility that someone *might* disagree with him; there was no proof that anyone did disagree with him. Moreover the statement was not particularized by reference to District practice in 1955. In any event even if reasonable specialists actually did differ on the witness stand—which, of course, did not happen here—the conflict would create merely a question of fact and would not compel the entry of a judgment as a matter of law for either party. See *Rogers v. United States*, 334 F.2d 931, 935 (C.A. 6, 1964); *Morton v. United States*, 233 F. Supp. 1011 (E.D.N.C., 1964). It is quite clear, as the court below ruled, that a physician is not liable for following one of two reasonable courses. This Court has long recognized that a physician “must have latitude for play of reasonable judgment * * *” (*Christie v. Callahan*, 75 U.S. App. D.C. 133, 136, 124 F.2d 825 (1941)). As the Tenth Circuit has held:

“If competent medical men can reasonably differ as to the best of several courses, the doctor is not negligent in pursuing one of them though a part of the profession may believe that another course might have produced better results.” *Graham v. Alcoa S.S. Co.*, 201 F.2d 423, 426 (C.A. 10, 1953), *cert. denied*, 346 U.S. 832.

Accord: *McHugh v. Audet*, 72 F.Supp. 394, 399 (M.D. Pa., 1947); *Peterson v. Carter*, 182 F.Supp. 393, 400 (W.D. Wis. 1960) *Gielskie v. State*, 9 N.Y. 2d. 834, 175 N.E.2d. 455 (1961). Consequently even accepting a view of the facts so favorable to appellant as to be unwarranted by this record, she was not entitled to a judgment.

B. *Alleged Failure to Consult with Appellant*

Since, as shown, there was no basis for a conclusion that sound medical practice required a repair of the tube in lieu of partial removal, there can be no liability for an asserted failure to communicate as to this non-existent alternative.

At trial appellant for the first time injected a new theory of liability—that the doctor should have advised her as to the possibility of post-operative repair. The court ruled, *inter alia*, that this theory was beyond the scope of the pleadings, opening statement and pretrial order and thus could not be heard (J.A. 186-188, 208). While it is true that a pretrial order may be modified “to prevent manifest injustice” (Rule 16, Fed. R. Civ. Pro.), the court has “justifiably large” discretion in the area,³ which discretion was certainly not abused under the circumstances of this case. Here there was no request to modify the order or amend the pleadings. Here the government objected to the tardy introduction of this new theory (J.A. 187) and the case was thus not one where the new issue had been tried by “implied consent” (see Rule 15(b), Fed. R. Civ. Pro.). Four months prior to the instant trial a mistrial had been declared before Judge Pine when appellant sought to raise some other new theories (J.A. 106). At that time it was apparently agreed that there were three claims of negligence, none of which involved the question of post-operative advice. Over a year and one half had elapsed between the date of the pretrial order and the date of the instant trial.⁴ Over nine years had passed between the date of the op-

³ *Gould v. Debeve*, — U.S. App. D.C. —, 330 F.2d 826, 828 fn. 2 (1964). The pertinent portion of the order reads “that what was done by the physicians was accomplished without adequate consultation with the P” (J.A. 4). This clause cannot fairly be read as reaching post-operative advice as to alleged repair measures.

⁴ Passage of considerable time between pretrial order and trial militates against allowing modification of the order so as to inject new theories of liability. *Payne v. S. S. Nabob*, 302 F.2d 803 (C.A. 2, 1962), *cert. denied*, 371 U.S. 870.

eration and the date of trial. Under all of these circumstances the court correctly ruled that appellant must be confined to the theories of liability embraced by the pleadings and pretrial order.

In any event, the court ruled against this theory on its merits and properly so (J.A. 208-209). While Doctor Hawken, appellee's expert, testified that generally post-operative repair might be successful in five to ten per cent of the cases (J.A. 186), this testimony was never made specifically applicable to the circumstances of appellant's case. For all that appears, under the peculiarities of her case, the chances of success could have been considerably less, or even non-existent. As the court ruled, there was no evidence to show that subsequent repair was possible in appellant's case, and there was no evidence to show that District medical practice in 1955 required a doctor or advise a patient as to the possibility of post-operative repair (J.A. 208-209).⁵ Moreover the doctor who performed the operation at bar stated that he "may" have or "very likely" did advise appellant as to this post-operative possibility (J.A. 42-43). Thus viewing the evidence in the light most favorable to appellee⁶ it is reasonable to conclude that if advice was required, it was given in this case.

C. Alleged Failure to Consult with Other Physicians

At the time of the operation Doctor Stafford Hawken was the "specified civilian consultant" available for consultation at any time (J.A. 34-35). Apparently he was not consulted prior to the operation on appellant. However this same Doctor Hawken, the very man who would

⁵ Appellant's counsel may argue that the court's ruling as to the untimeliness of the theory foreclosed any further proof as to liability thereon. However counsel was still free to make an offer of proof, if indeed, he was prepared to establish that there was a departure from sound medical practice in relation to post-operative advice. Absent at least an offer of proof, there is simply nothing in this record to support liability on the new advice theory.

⁶ *Price v. Neyland*, 115 U.S. App. D.C. 355, 320 F.2d 674 (1963).

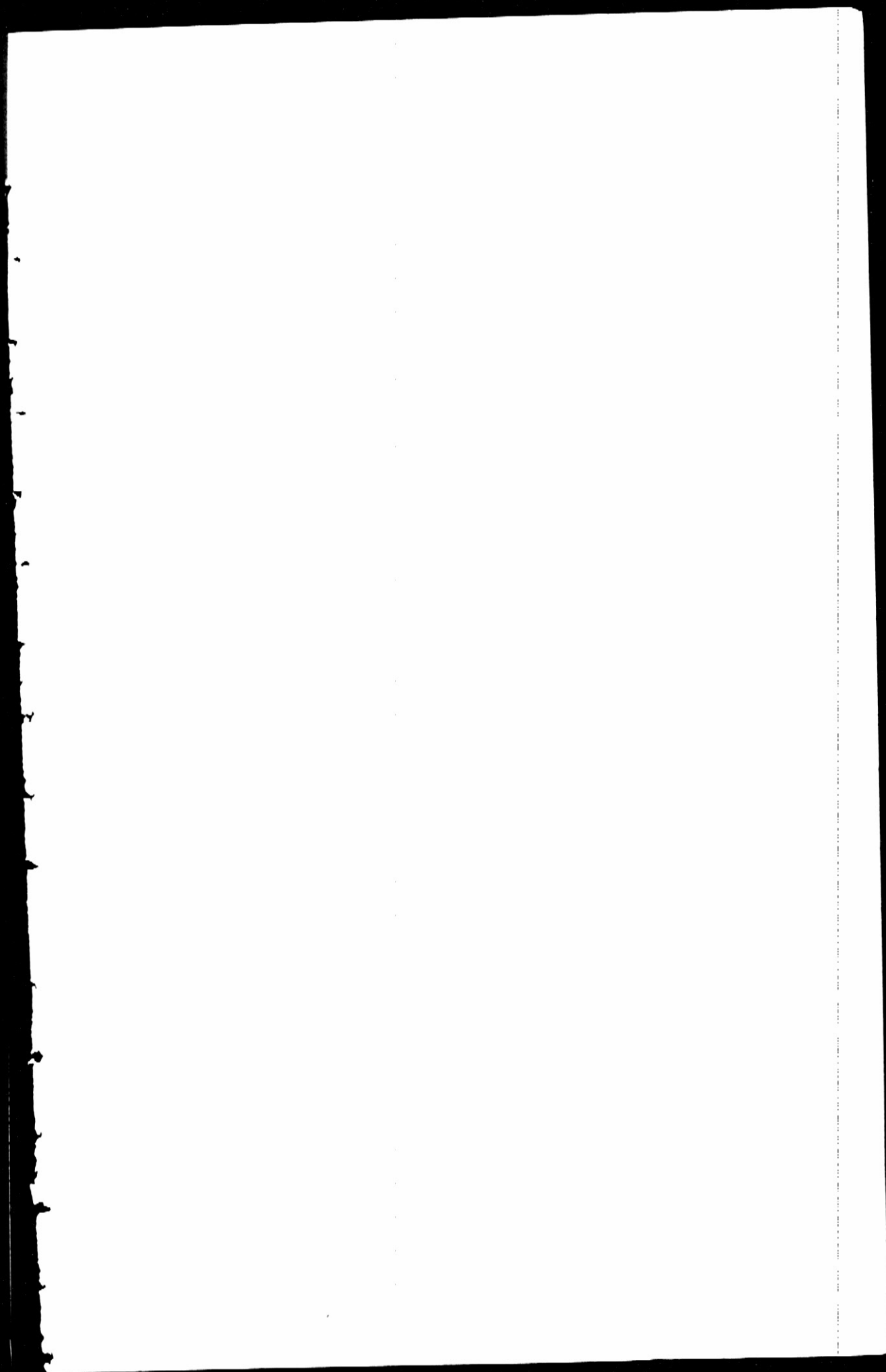
have been consulted, testified at trial that the operation was in accord with sound medical practice and that indeed to have proceeded in harmony with appellant's "repair" theory would have amounted to a departure from accepted practice (J.A. 172, 174). Moreover because of the seriousness of tubal pregnancy, there is an element of urgency surrounding the operation. As Doctor Hawken said "the idea of operating on an ectopic is that you are operating on a bleeding organ. Your idea is to operate on that bleeding organ, stop it from bleeding and get out of there. It has been constantly told us and we teach it all the time in an ectopic you get in and get out." (J.A. 179). Consequently as the court ruled (J.A. 203-204), the situation had to be handled promptly, and further there was no basis for an inference that consultation might somehow have produced any different result.

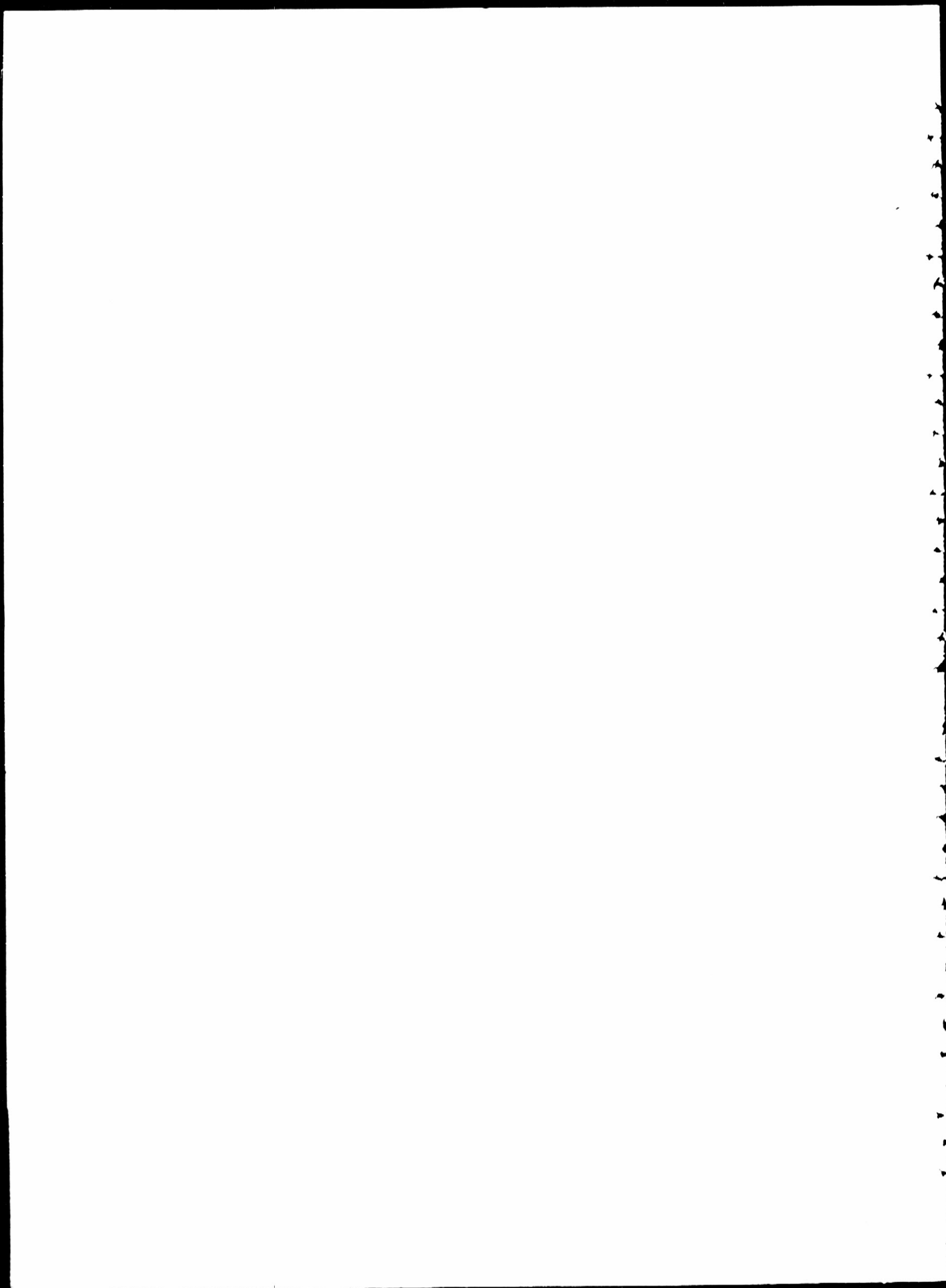
CONCLUSION

WHEREFORE, it is respectfully submitted that the judgment of the District Court should be affirmed.

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 18,823

GEORGIANA HARVEY

Plaintiff-Appellant,

v.

UNITED STATES OF AMERICA

Defendant-Appellee.

*Appeal From the United States District Court
for the District of Columbia*

United States Court of Appeals
for the District of Columbia Circuit

FILED APR 8 1965

Nathan J. Paulson
CLERK

PETITION FOR REHEARING PETITION FOR HEARING EN BANC

Appellant Georgiana Harvey moves the court under Rule 26 to grant a rehearing in this cause, and also, pursuant to 28 U.S.C. 46, to grant a hearing en banc, and for reason therefor shows:

The weight and admissibility of evidence in this case was determined according to the following standards:

"There are times when it is very difficult to prove malpractice, yes. I think perhaps it should be difficult, for the doctor's protection, because there are many unfounded claims . . .

"I think a good deal of that supposed difficulty is speculative . . .

"I think if it [were] contrary to proper practice . . . I shouldn't think you would have much difficulty getting some specialist to say so." (JA 150-151).

The attention of the trial court was specifically directed to the following language from *Christie v. Callahan*, 75 U.S. App. D.C. 133, 124 F.2d 825 as quoted in *Goodwin v. Hertzberg*, 91 U.S. App. D.C. 385, 201 F.2d 204:

"Malpractice is hard to prove. The physician has all the advantage of position . . . What therefore might be slight evidence where there is no such advantage, as in ordinary negligence cases, takes on greater weight in malpractice suits."

The court rejected this as "dicta," and explained why, in its view, a stricter standard of proof was required:

"There are two things involved here. It isn't just a question of money. In all these cases involving physicians when they are sued for negligence professional reputation is at stake as well as the question whether somebody should pay some money to somebody else." (JA 152).

No opinion of this court has ever expressly repudiated the rulings in *Christie v. Callahan* and *Goodwin v. Hertzberg*. However, it is plain that the liberal standards of proof in those cases have not been followed in such recent cases as *Quick v. Thurston*, 110 U.S. App. D.C. 169, 290 F.2d 360, at 6-3, en banc ruling in 1961, and *Brown v. Keaveny*, 117 U.S. App. D.C. 117, __ F.2d __, in which a petition for hearing en banc was denied last year.

The divergent standards of proof, and more importantly, the divergent results they lead to in this court, should be resolved; or, if not resolved, at least elucidated with more care.

In addition to the ordinary judicial motives for resolving this conflict, it must be remembered that the courts themselves are largely responsible for the public opinions about malpractice litigation which lie at the root of the problem. Consider the wide range of public discussion represented by a sampling of hundreds of publications on this subject: Judge Carter in *Huffman v. Lindquist*, 37 Cal. 2d. 465, 234 P.2d. 465 (1951); Belli, "An Ancient Therapy Still Applied: The Silent Medical Treatment," 1 Villanova Law Rev. 250(1956); Silverman, "Medicine's Legal Nightmare," in two parts in the Saturday Evening Post, April 18 and 25, 1959; Lotito, "Conspiracy of Silence" in the Washington Post February 9, 1964. See also, for example, in the Journal of the Bar Association of the District of Columbia (JBADC), the first Report of the Committee on Relations with the Medical Society, 17 JBADC 532 (1950); James A. Gannon, M.D., The Medical Witness, 25 JBADC 536 (1958); James A. Gannon, M.D., The Doctor and the Lawyer, 25 JBADC 132 (1958); Raymond A. Osbourn, M.D., The Tuscon Plan, 26 JBADC 96 (1959).

So far no one has been so optimistic as the trial judge in this case who asserted, "There used to be a time when the so called conspiracy of silence perhaps existed . . . but if so, it is no longer the case . . ." (JA 195). No one is reassured by such placebos (JA 195-196), and the failure of the courts to deal with this problem realistically and openly aggravates it.

This case provides striking illustrations of such aggravation in the practical consequences of rejecting a liberal standard of proof in favor of a strict one. Among other things, the lower court:

(1) Interpreted the deposition of the attending physician in a light most favorable to him, accepting, without question, his judgment in the

matter at issue (See Appellant's Brief, pp. 4-6, 20-24). The manner of interpreting evidence in malpractice cases was the immediate point involved in *Quick v. Thurston*, supra. Because of the non-availability of expert witnesses to the plaintiff, he must be resourceful in finding other ways to establish his case. Cross examination of the physician is the most usual way (See *Belli*, supra). This is a very difficult road. The physician has all the advantage as the trial judge in this case recognized:

"I have often said to lawyers that one of the most fruitless things is to try to cross-examine an expert witness who is a competent expert and is telling the truth as he knows it, I have never yet seen anything accomplished by it." (JA 195).

A real appreciation of this, however, would lead one precisely to the point of the *Christie* case:

"What therefore might be slight evidence where there is no such advantage, as in ordinary negligence cases, takes on greater weight in malpractice suits."

(2) Held that an "adequate consultation" with the patient did not include advice after the operation about the possibility of restorative surgery, prohibiting cross examination on this and other relevant subjects (See Appellant's Brief, pp 6-10, 24-26). Another way of establishing a malpractice case without an expert witness is to use your opponent's (See *Belli*, supra). This too is a difficult way, and an impossible one if cross examination is restricted.

(3) Excluded evidence of published hospital standards accepted by practically all hospitals in the metropolitan area as "hearsay" and "textbooks" insufficient to establish standard of care (Appellant's Brief pp. 11-14, 28-29). Here another avenue of substitution for the unavailable expert is closed by a technical reading of a doubtful rule.

(4) Demanded proof of causation, which, of its very nature was impossible to obtain (Appellant's Brief, pp 27-28). Here again we en-

counter a failure to take into consideration the kind of proof of which the proposition is capable. An unrealistic appraisal of this point is, for all practical purposes, an amendment of the substantive law.

Conclusion

The upshot of all of this is to obscure completely the process whereby plaintiff lost a fundamental human right, a right which the Supreme Court calls "basic to the perpetuation of the race — the right to have offspring . . . one of the basic civil rights of man." *Skinner v. Oklahoma* 316 US 535. Such a result is by its very nature a matter of grave public concern. This court has in the past concerned itself with protection of individual freedom of choice in a matter so necessary as blood transfusions. Cf. *Application of the President and Directors of Georgetown College*, __ U.S. App. D.C. __, No. 2189 decided February 3, 1964, 331 F.2d 1000 and 1010. Yet here, without anything remotely resembling the protection and explanation attending the blood transfusion issue, plaintiff was sexually sterilized upon the judgment of a single physician.

It would seem therefore that a reexamination and reconciliation of this court's opinions is now in order if fundamental human rights are not to be swept away in obscurity by a cloud of technical niceties.

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CERTIFICATE OF COUNSEL

I hereby certify that the foregoing Petition for Rehearing is presented in good faith and not for delay.

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Petition for Rehearing and Petition for Hearing in Banc has been served by mailing a copy thereof, postage prepaid, this 8th day of April, 1965 to counsel of record for appellees as follows:

JEROME NELSON and
DAVID C. ACHESON,
United States Attorney
U. S. Court House
Washington 1, D. C.

